STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365770	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32801 Based on record review, review of anonymous complaint, observation, review of statements, interviews, and policy review the facility failed to ensure residents were treated respect and dignity. This had the potential to affect all 74 residents residing in the building. Findings included: 1. Confidential information provided from a facility visitor revealed prior to 11/04/22 (exact date not provided) the visitor saw and heard Resident #77 be verbally abusive to another female resident and staff. The resident yelled profanity and made inappropriate comments to multiple individuals all the time. The family member had also seen the resident sit by the nurse's station with his private areas hanging out and the resident did not care. The visitor stated he/she avoided leaving the resident's room they were visiting with unitl Resident #77 calmed down because of how violent Resident #77 gets. Interview on 01/25/23 at 8:38 A.M., with the Ombudsman revealed back in first part of December 2022 (exact date unknown) her co-worker overheard a facility staff member verbally abuse Resident #77. The Ombudsman stated her co-worker had reported the incident to the facility, however the facility did not complete a facility reported incident (FRI) to the state upon reporting the incident and recommendations. The Ombudsman reported she had followed up with the resident at a later time and he reported he did not feel the nurse was abusive towards him. Interview on 01/25/23 at 8:52 A.M., with the Director of Nursing (DON) revealed the facility did not complete and FRI, because she had interviewed Resident #77 and he felt the nurse was just overwhelmed and the resident reported he was happy she could vent. The nurse was sent home and has not returned since the incident. Interview on 01/25/23 at 10:00 A.M., with anonymous staff member #100 revealed there was an incident a staff member verbally abused a resident. The staff member did not know details on what was said but it did involve Resident #77. Review of Resident #77 typed statement involving an incident the Ombudsman had observed dated 12/08/22 revealed the resident had signed a typed statement that stated the resident denied being verbally abused and reported he was glad the nurse was able to vent and he was trying to help her calm down. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #77 progress notes dated 12/01/22 to 01/05/23 revealed the resident was discharged home with Activities Aide #66. The resident was noted to yell and curse down the hallway to staff when medication was not available. Interview on 01/26/23 at 10:22 A.M., with Resident #48 reported there was a resident (Resident #77) that would be in public areas with his genitals exposed and his shirt raised above his belly. Interview on 01/26/23 at 1:53 P.M., with Resident #6 revealed Resident #77 private areas were frequently visible and he had frequent outburst towards residents and staff, including to her. He has threaten to hit her and had a verbal altercation with her recently. Interview on 01/31/23 at 1:26 P.M., with an anonymous staff member #103 confirmed Resident #77 had explosive behaviors and would be disrespectful/argumentative with residents and staff. Interview on 01/31/23 at 3:15 P.M., with an anonymous staff member #102 confirmed Resident #77 would flip out on resident and staff. He would yell, curse, and scream at them. His clothes did not fit properly, and his privates were exposed. The activities aide was buying him clothes that fit better. 2. Interview on 01/30/23 at 9:41 A.M., with Resident #65's wife and daughter revealed staff were constantly using the F word and it really bother them. State tested Nurse's Aide (STNA) #40 used the F word six hours straight on Christmas Day. Interview on 01/31/23 at 3:17 P.M., with STNA #40 verified she had used an illicit word on Christmas Day when the pipes above her head had busted and water fell on her head. 3. Interview on 01/25/23 at 12:30 P.M., with Resident #56 revealed she has heard staff using illicit words towards cognitively impaired Resident #44 when staff found him incontinent of urine. Interview on 01/30/23 at 10:35 A.M., with Resident #6 revealed on Saturday she had asked the Activities Assistant #66 if she could have her cigarettes and the Activities Assistance replied smartly Why don't you have them, you have them another time. Resident #6 reported she had a verbal altercation with Resident #77, whom the Activities Assistance was now living with because she was having an inappropriate relationship with the resident and took him home after the altercation between her and Resident #77. She did not feel the Activities Assistant treated resident with respect and dignity on several occasions. Interview on 01/31/23 at 8:45 A.M., with Resident #36 confirmed staff do not treat residents with respect or dignity. Resident #36 had concerns just this past weekend with Licensed Practical Nurse (LPN) #38. LPN #38 wanted him to take a shower on Sunday instead of Monday (his scheduled shower day) and he did not want a shower Sunday, because he had a doctor's appointment Monday and wanted a shower prior to going to his appointment. The LPN yelled down the hall He refused his shower and now I will have to re-document everything. He was also having bowel issues and he was trying to tell her. The LPN kept repeating What when he was trying to talk to her. The resident reported he did not want the resident in the dining room to hear his issues, but the LPN kept just saying What, so he spoke up and then looked at the resident in the dining room and said I hope everyone heard. The same nurse also leaves his pills in his room on the bedside table when he was sleeping or when he was not in his room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/31/23 at 1:26 P.M., with an anonymous staff member #103 confirmed staff do curse but it's not directed towards residents. Observation on 02/01/23 at 12:38 P.M., revealed two surveyors were sitting in the conference room on 100 halls with the door closed when a staff member yelled God damn that alarm is going off again. The surveyor opened the door and confirmed with STNA #50 what was heard, and she indicated it was not intentional. Review of the facilities policy titled Resident Rights and Facility Responsibilities undated the resident has a right to a dignified existence. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. This deficiency represents non-compliance investigated under Master Complaint Number OH00138950 and Complaint Number OH00136553.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of the concern log, review of anonymous complaint, review of resident council minutes, interview, and policy review the facility failed to provide written evidence of response and rationale to resident/representative/family concerns. This affected four sampled residents (#36 #75, #76, #79) reviewed for resident and family concerns. The facility census was 74. Findings included: 1. Confidential information provided from a facility visitor revealed Resident #79 had not received his intravenous antibiotics nor did the facility administer his wound vac all week and it was Saturday. Review of the facility's concern log dated [DATE] to [DATE] revealed no concern related to Resident #79 nor concern related to wound vac/intravenous antibiotics. Interview on [DATE] at 2:00 P.M., with the Director of Nursing (DON) revealed Resident #79's and his family had voiced concerns to her, however she did not complete a concern form nor had documented evidence response or rational to voiced concerns. The DON reported she doesn't keep track of family/resident concerns. 2. Interview on [DATE] at 8:38 A.M. with the Ombudsman revealed she had been working on an open case regarding Resident #76 missing wallet that contained his social card, driver's license, and a credit card. The Ombudsman reported the family reported the missing items to the Director of Nursing (DON) on [DATE] and there still was no resolution. Interview on [DATE] at 8:52 A.M., with the DON revealed Resident #76 niece had reported the wallet and its contents missing on [DATE], however the facility did not complete a concern form or facility reported incident (FRI) due to the resident had expired the day before the family reported the missing items. The DON reported she doesn't keep track of family/resident concerns. Interview on [DATE] 9:00 A.M., interview with Administrator revealed the facility was aware of the wallet and missing contents, however the facility did not complete and concern form or FRI. Review of the facility's concern log dated [DATE] to [DATE] revealed no evidence of Resident #79's missing wallet reported by the family to the facility on [DATE] was on the log. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Confidential information provided from a facility visitor revealed revealed on [DATE] at 11:00 P.M., the family had reported to Licensed Practical Nurse (LPN) #35 that Resident #75 had stopped breathing. The resident was under hospice care. The nurse came in and stated the resident still had a pulse. The nurse did not have a stethoscope at that time or listened to her heart for a pulse. The nurse mumbled and said she would be back. A half hour later the nurse never returned. The family gathered the resident items and exited the room knowing she had passed away. The nurse was at the nurse's station and the family told her they were leaving since the resident was gone. A family member called into the facility that works there and asked the nurse why she hasn't checked on the resident. The family that was there stated she had stopped breathing and no one has checked on her. The nurse stated she would check and hung up. The nurse had the State tested Nurse's Aide (STNA) call the family back and stated that the resident was still breathing. The family member told the nurse well you better call the family and tell them she's alive since they left thinking she was gone. The nurse hung up. The DON called in and spoke to nurse again and then the nurse finally stated patient was gone and hung up. The resident was released to the wrong funeral home and the family tracked down the resident and had her transported to the correct funeral home. Interview on [DATE] at 2:29 P.M., with the DON revealed there was concerns voiced regarding Resident #75's death. The granddaughter of Resident #75, whom also works at the facility, felt LPN #35 did not properly assess Resident #75 when family reported she had passed and being transported to the wrong funeral home after she expired. The DON reported she had the staff write written statements that night the resident expired regarding the assessment issue because she knew it was going to be a problem when a family member called in and yelled at nurse regarding her grandmother's care. Review of the facility's concern log dated [DATE] to [DATE] revealed no evidence Resident #75's family's concerns regarding care and transporting to the wrong funeral home were addressed. 4. Interview on [DATE] at 2:35 P.M., with Resident #36 revealed he had concerns with the new residents that were temporarily placed at the facility around Christmas time. He had reported his concern to the DON and Administrator, however nothing was resolved. The new resident was not following rules (smoking, drinking, threatening other residents). Interview on [DATE] at 3:26 P.M., with the DON revealed she was aware of Resident #36 issues and had talked with in several times. Review of the facilities concern log dated [DATE] to [DATE] revealed no evidence Resident #36's concerns or evidence they were addressed. 5. Interview on [DATE] at 12:30 P.M., with Resident #56 revealed she has voiced several concerns to the facility and the DON always makes excuses up for the staff and states they are short staffed. Interview on [DATE] at 2:00 P.M., with the Administrator and DON revealed not all concerns are logged and documented on. The staff confirmed there was only two concerns documented on the log since [DATE]. Review of the facility's concern log dated [DATE] to [DATE] revealed there was only two concerns on the entire log. One dated [DATE] regarding a missing $20, which was found in the laundry and [DATE] regarding a missing gift card that was replaced. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident Council Minutes dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] revealed there was no concerns voiced. Review of the facility's policy titled Concerns/Grievance dated ,d+[DATE] revealed it was the facility to honor the resident's right to voice concerns and/or grievances without discrimination or reprisal. Such concerns and/or grievances will include, but not limited to, treatment which has been furnished as well as that which has not been furnished and instances of behavior of other residents. Other forms of grievances could include management of funds, lost items and/or violation of rights. The Administrator/designee will forward the concern form to the appropriate management representative. The representative will investigate all concerns by interviewing staff present at the time of the event and reviewing all pertinent records for information. A copy of these records is to be attached to the form. The findings of the investigation are to be documented in the Investigation section of the form. Social Services will maintain a Concern Log in order to track concerns and/or missing items. This deficiency is cited as an incidental finding to Master Complaint Number OH00138950.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of work orders, observation, interviews, and policy review the facility failed to ensure the resident's environment was clean and safe. This affected 17 residents (#44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, and #60) of 17 residents who use the Southeast shower room and one (#56) of three resident bathrooms observed for water leaks. The facility census was 74. Findings included: 1a. Interview on 01/25/23 at 12:30 P.M., with Resident #56 revealed the Southeast shower room was filthy dirty and filled with equipment. The Resident reported there had been a huge ball of hair near the chair in the shower room that's been there a month. Observation on 01/25/23 at 1:58 PM., of Southeast shower room with State tested Nurse's Aide (STNA) #25 verified there was a ball of hair as large as a baseball near the chair next to sink in the shower room. There were three shower stalls in the bathroom, however two of three were filled with equipment and supplies. All three showers, including the shower stall the residents were using were filthy dirty. There was soap scum build-up, hair, and dusty in the showers and on the floors. STNA #25 confirmed findings during the observation. Interview on 01/25/23 at 2:29 P.M. with the Director of Nursing (DON) revealed she would have staff clean/scrub the bathroom and remove the extra equipment and supplies. 1b. Observation on 01/31/23 at 2:00 P.M., of Southeast shower room with DON and Administrator revealed the shower stalls were still filthy dirty. The surveyor made a S in the soap scum with her finger on the resident's shower stall wall. The other two shower stalls were still dirty. They still had dust and hair in them that was originally observed on 01/25/23 by the surveyor. The supplies and extra equipment were removed. Interview on 01/31/23 at 2:00 P.M., with the DON and Administrator verified the shower stalls were still dirty and would have maintained clean the shower stalls. Interview on 01/30/23 at 9:11 A.M. to 10:45 A.M., with anonymous staff members #100, #102, and #103 revealed the male housekeeping staff don't always do a thorough job cleaning on South hall as the female housekeeper that had worked there for years. 2. Observation on 01/25/23 at 9:09 A.M., of Resident #56 toilet in room [ROOM NUMBER], with the MD revealed the toilet in the residents' bathroom was leaking at the base of the toilet and there was a wet bath blanket wrapped the base of the toilet. The MD reported the toilet concern was just reported to him yesterday (01/24/23) and he was going to replace it today with an extra toilet he had in storage. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/25/23 at 12:30 P.M., with Resident #56 revealed the toilet in her room had been leaking since she was admitted at the end of December 2023. The resident confirmed staff were aware the toilet was leaking and would occasionally replace the bath blanket when it was wet. The other day one of the custodian told her she would put a work ticket in to have it repaired but no one had come to work on it or repair it yet. Interview on 01/30/23 at 10:45 A.M., with Resident #56 revealed the MD told her Thursday (01/26/23) he would replace her toilet on Monday (01/30/23), however Friday she tripped and slid on the wet bath blanket in the bathroom resulting in her twisting her ankle and tore off her great toenail, so the MD came in on Saturday and replaced the toilet. Review of Resident #56 therapy note dated 01/30/23 revealed the resident reported she had twisted her right ankle and ripped her big toe nail off in the bathroom last Friday due to water on the floor. Review of work order dated 01/20/23 revealed room [ROOM NUMBER]'s toilet was leaking. On 01/23/23 a note indicating it was completed, however the MD reported in an interview on 01/25/23 at 9:09 A.M., he was just notified the toilet was leaking. Review of the facilities policy titled Routine Cleaning and Disinfection dated 2020 revealed the facility policy to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development of and transmission of infections to the extent possible. Cleaning was defined as the removal of visible soil from the objects and surfaces and was normally accomplished manually or mechanically using water and detergents or enzymatic products. This deficiency represents non-compliance investigated under Complaint Number OH00136553.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interviews, review of Facility Reported Incidents (FRI), review of concern log, review of the facility's investigation, review of disciplinary action form, and policy review, the facility failed to ensure allegations of misappropriation and verbal abuse was reported timely to the state agency. This affected two residents (#76 and #77) of three records reviewed for abuse. Findings included: 1. Interview on [DATE] at 8:38 A.M., with the Ombudsman revealed Resident #76 expired on [DATE]. On [DATE] his niece had reported to the facility that her uncle's wallet containing his credit card, driver's license, and social security card was missing. The Ombudsman reported she was still awaiting on information from the facility before she can close her case. The Ombudsman indicated the facility never reported the incident to the state agency. Interview on [DATE] at 8:52 A.M., with the Director of Nursing (DON) verified Resident #76's expired on [DATE] and the next day the resident's niece had visited the facility looking for her uncle's wallet that contained his social security card, driver's license, and a credit card. The DON reported she searched the residents room and checked the medication carts and medication rooms, called the funeral home, and was not able to find the wallet and its contents. The DON reported the Administrator called the facilities corporate office and the corporate office directed the Administrator not to file and FRI due to the resident was no longer a resident at the facility since he expired the day before and the facility was not required to file an FRI since he was not a current resident. There was documented evidence the facility completed a thorough investigation, however the DON reported she had verified with an STNA (STNA #25) that the resident did have a wallet during his stay. Interview on [DATE] at 9:00 A.M., with the Administrator revealed the facilities corporate office told him he was not required to file and FRI since Resident #76 was deceased and not in the facilities system. The Administrator confirmed the resident expired on [DATE] and the misappropriation was reported on [DATE]. Interview on [DATE] at 10:00 A.M., with STNA #25 verified Resident #76 had a wallet in his possession since he was admitted to the facility. The last time she worked was on Thursday and the wallet was lying on the corner of the resident's bedside table. She did not know what the wallet contained. Interview on [DATE] at 2:29 P.M., with the DON revealed she had typed up a statement today with a timeline of events regarding Resident #76's missing wallet. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of undated statement from the DON revealed on [DATE] Resident #76's niece came into the facility and reported the resident's black wallet was missing that contained his driver's license, social security care, and credit card. The room was searched, and no personal belongings were found. The medication carts and rooms and laundry were also searched, and no wallet was found. The house keeper was interviewed who cleaned the room, the day shift STNA recalls seeing the wallet last week but could not recall the day. STNA #50 reported she seen the wallet on his tray table on [DATE] before the end of her shift. On [DATE] the medication and carts were searched again and not wallet was found. On [DATE] the funeral home was contacted, and no wallet was taken to the funeral home. The DON posted a message twice on the dashboard regarding the messing wallet, but no response. Review of the facility's FRI dated [DATE] to [DATE] revealed no evidence of FRI was submitted regarding Resident #76's wallet and contents. Review of the facility's concern log dated [DATE] to [DATE] revealed no evidence of a concern related to Resident #76's missing wallet and contents. 2. Interview on [DATE] at 8:38 A.M., with the Ombudsman revealed one of her co-workers witnessed a facility staff member verbally abuse a resident (Resident #77). The staff member yelled This is too much; I can't take it. The staff members voice was so loud staff had come running to see what was going on. The Assistant Director of Nursing (ADON) ran in and took over the situation. The ombudsman had reported to the facility the resident was verbally abused by the staff member, however the facility never reported the incident to the state. On [DATE] the ombudsman had spoken to the resident and reported he didn't feel the staff was abusive. Interview on [DATE] at 8:52 A.M., with the DON revealed the facility did not complete a FRI regarding the incident involving the nurse and former Resident #77 due to she had interviewed the resident and he did not feel the nurse was verbally abusive and was just overwhelmed and he was just trying to comfort her and let her vent. The DON reported the nurse was Registered Nurse (RN) #31. The DON confirmed she did not interview any other resident or staff to ensure the nurse had not verbally abused any other residents. Interview on [DATE] at 9:00 A.M., with the Administrator confirmed he did not file a FRI or concerns form regarding the incident between RN #31 and former Resident #77. Review of Resident #77 typed statement dated [DATE] revealed Resident #77 signed a statement that contained two question, which he answered No to both question. The first question was do you feel like you were verbally abuse and the second question was do you feel like the nurse was angry with you. The was a typed statement at the end I was glad she was able to vent and I was trying to help her calm down. There was no evidence of statements from staff, residents, or the ombudsman, or anyone who might have witnessed the incident. There was no statement from the RN, no evidence of date and time of the incident, no evidence what the nurse said to indicate the allegation of verbal abuse, or no evidence residents were assessed that were not interviewable to ensure the nurse did not verbally abuse any other residents. Review of RN #31's disciplinary action form dated [DATE] revealed the RN receive a verbal warning for code of conduct. There were no details of the incident. The form was signed by DON and RN #31. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's FRI dated [DATE] to [DATE] revealed no evidence of FRI was submitted regarding allegation of verbal abuse involving former Resident #77. Review of the facility's concern log dated [DATE] to [DATE] revealed no evidence of a concern related to allegation of verbal abuse regarding former Resident #77. Review of the facility's policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated ,d+[DATE] revealed It was the facility's policy to investigate all alleged violation of abuse, neglect, exploitation, and mistreatment of a resident, or misappropriation of resident's property. Facility staff should immediately report all such allegations to the Administrator and the State Agency in accordance with the procedures in this policy. Residents interested family members, or other persons may contact any member of the administration or the facilities nursing staff at any time with the concerns relating to abuse, neglect, exploitation, or misappropriation. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of the resident's belongings or money without the consent. Abuse was defined as willful (the individual must have acted deliberately) infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The Administrator or designee would notify the state agency of alleged violation as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known to the staff member. Once the Administrator and state agency are notified, an investigation of the allegation violation would be conducted. This deficiency represents non-compliance investigated under Master Complaint Number OH00138950 and Complaint Number OH00136553.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365770	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interviews, review of Facility Reported Incidents (FRI), review of concern log, review of the facility's investigation, review of disciplinary action form, and policy review, the facility failed to ensure allegations of misappropriation, sexual abuse, and verbal abuse was thoroughly investigated and residents were protected during the investigation. This affected three residents (#31, #76 and #77) of three residents reviewed for abuse. The facility was 74. Findings included: 1. Interview on [DATE] at 8:38 A.M., with the Ombudsman revealed Resident #76 expired on [DATE]. On [DATE] his niece had reported to the facility that her uncle's wallet containing his credit card, driver's license, and social security card was missing. The Ombudsman reported she was still awaiting on information from the facility before she can close her case. The Ombudsman indicated the facility never reported the incident to the state agency. Interview on [DATE] at 8:52 A.M., with the Director of Nursing (DON) verified Resident #76's expired on [DATE] and the next day the resident's niece had visited the facility looking for her uncle's wallet that contained his social security card, driver's license, and a credit card. The DON reported she searched the residents room and checked the medication carts and medication rooms, called the funeral home, and was not able to find the wallet and its contents. The DON reported the Administrator called the facilities corporate office and the corporate office directed the Administrator not to file and FRI due to the resident was no longer a resident at the facility since he expired the day before and the facility was not required to file an FRI since he was not a current resident. There was no documented evidence the facility completed a thorough investigation, however the DON reported she had verified with an STNA (STNA #25) that the resident did have a wallet during his stay. Interview on [DATE] at 9:00 A.M., with the Administrator revealed the facility's corporate office told him he was not required to file a FRI since Resident #76 was deceased and not in the facility's system. The Administrator confirmed the resident expired on [DATE] and the misappropriation was reported on [DATE]. Interview on [DATE] at 10:00 A.M., with STNA #25 verified Resident #76 had a wallet in his possession since he was admitted to the facility. The last time she worked was on Thursday and the wallet was lying on the corner of the resident's bedside table. She did not know what the wallet contained. Interview on [DATE] at 2:29 P.M., with the DON revealed she had typed up a statement today with a timeline of events regarding Resident #76's missing wallet. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of undated statement from the DON revealed on [DATE] Resident #76's niece came into the facility and reported the resident's black wallet was missing that contained his driver's license, social security care, and credit card. The room was searched, and no personal belongings were found. The medication carts and rooms and laundry were also searched, and no wallet was found. The house keeper was interviewed who cleaned the room, the day shift STNA recalls seeing the wallet last week but could not recall the day. STNA #50 reported she seen the wallet on his tray table on [DATE] before the end of her shift. On [DATE] the medication and carts were searched again and not wallet was found. On [DATE] the funeral home was contacted, and no wallet was taken to the funeral home. The DON posted a message twice on the facility message dashboard regarding the missing wallet, but no response. 2. Interview on [DATE] at 8:38 A.M., with the Ombudsman revealed one of her co-workers witnessed a facility staff member verbally abuse resident (Resident #77). The staff member yelled This is too much; I can't take it. The staff members voice was so loud staff had come running to see what was going on. The Assistant Director of Nursing (ADON) ran in and took over the situation. The ombudsman had reported to the facility the resident was verbally abused by the staff member, however the facility never reported the incident to the state. On [DATE] the ombudsman had spoken to the resident and reported he didn't feel she was abusive. Interview on [DATE] at 8:52 A.M., with the DON revealed the facility did not complete a FRI regarding the incident involving the nurse and former Resident #77 due to she had interviewed the resident and he did not feel the nurse was verbally abusive and was just overwhelmed and he was just trying to comfort her and let her vent. The DON reported the nurse was Registered Nurse (RN) #31. The DON confirmed she did not interview any other resident or staff to ensure the nurse had not verbally abused any other residents. Interview on [DATE] at 9:00 A.M., with the Administrator confirmed he did not file a FRI or concerns form regarding the incident between RN #31 and former Resident #77. Review of Resident #77 typed statement dated [DATE] revealed Resident #77 signed a statement that contained two question, which he answered No to both question. The first question was do you feel like you were verbally abuse and the second question was do you feel like the nurse was angry with you. The was a typed statement at the end I was glad she was able to vent and I was trying to help her calm down. There was no evidence of statements from staff, residents, or the ombudsman, or anyone who might have witnessed the incident. There was no statement from the RN, no evidence of date and time of the incident, no evidence what the nurse said to indicate the allegation of verbal abuse, or no evidence residents were assessed that were not interviewable to ensure the nurse did not verbally abuse any other residents. Review of RN #31's disciplinary action form dated [DATE] revealed the RN receive a verbal warning for code of conduct. There were no details of the incident. The form was signed by DON and RN #31. Review of the facility's FRI dated [DATE] to [DATE] revealed no evidence of FRI was submitted regarding allegation of verbal abuse involving former Resident #77. Review of the facility's concern log dated [DATE] to [DATE] revealed no evidence of a concern related to allegation of verbal abuse regarding former Resident #77. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Interview (via sign language and written communication due to the resident was deaf) on [DATE] at 2:10 P. M., with Resident #31 revealed the resident reported she had been in the hospital recently because of a sexual assault. The resident handed the surveyor the hospital discharge paperwork. The hospital records dated [DATE] indicated a man had touched her breast, private area, and kissed her neck. The resident reported the incident happened between 8:00 P.M. and 10:00 P.M. The resident reported she was lying in bed, and she felt someone (Resident #48) touching her on the outside of her clothing and kissing up and down her neck. She told the resident to stop. He left her room and then sent her a text message afterwards apologizing. She had known Resident #48 because he volunteers helping with bingo and projects in the facility. Resident #31 reports she was afraid of Resident #48 and thought he was going to have sex with her. She reported the incident to staff but could not remember the staff member's name. Review of the FRI (231336) and investigation dated [DATE] revealed on [DATE] about 5:00 P.M., Social Service Director (SSD) #104 received a text from Resident #31 indicating she might need to call 911 but couldn't indicate why on the phone. At 6:00 P.M., the DON notified the Administrator. The incident occurred on [DATE] between 8:00 P.M. to 10:00 P.M. and the alleged perpetrator was Resident #48. Resident #31 reported Resident #48 had put his hands on her breast and rubbed her thighs and kissed her neck. Resident #31 was sent to emergency room for evaluation. Resident #48 denied entering the resident's room on [DATE] and any time he had been in her room the door was opened. Resident #48 was told he should not be in any female residents' rooms. The incident was reported to the local police department. Further review of the investigation revealed two female residents reported Resident #48 had made comments to them in the past but denied being afraid of him or feeling unsafe in the facility. Staff had observed Resident #48 on Resident #31 unit the night of the alleged incident, but not in Resident #31's room. Staff reported Resident #48 was getting a TV out of the storage room on Resident #31 unit around 7:45 P.M. Resident #48 resides in room [ROOM NUMBER], which is in the front of building and Resident #31 resides in room [ROOM NUMBER] which was in the back of the building. Review of the text messages that was part of the investigation dated [DATE] to [DATE] revealed Resident #48 had sent an emoji with heart eyes and a second message of two people kissing. Resident #31 responded back No thank. On [DATE] Resident #48 sent a kiss emoji and texted he missed her. Resident #31 responded back Stop. Review of text message undated between Social Services Designee #104 and Resident #31 revealed at 4:57 P.M. (date unknown) Resident #31 had asked to speak to someone who could interpret and was a serious big boss about a private matter she did not want anyone to know about. She also indicated she needed someone to watch her room. She indicated she could not tell by phone due to it was private and she might need to call 911. Review of staff statements indicated Licensed Practical Nurse (LPN) #35 reported the resident was observed on Resident #31's hall (North) around 8:00 P.M., getting a television out of storage for a new resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #48 statement dated [DATE] (date was an error) revealed he visits Resident #31 every day for months because they are friends. As he was coming down the hall he saw her light was on, so he asked what she needed and she said a box of tissues. He went and got her a box of tissues from the nurse. He left and told her he would be back later and patted her wrist like he always does when he leaves. Resident #48 reported she hit him up first on messenger. There was no evidence of dates or times of the events. Review of text message from Resident #48 to Resident #31 that was not part of the originally investigation and was requested by surveyor revealed on [DATE] at 5:40 P.M., Resident #48 asked Resident #31 if she was mad at him. The facility's corrective action was to advise Resident #48 to stay out of female resident rooms. There was no evidence Resident #48 was monitored during the investigation to ensure he had no contract with Resident #31 or entered other female resident rooms. There was no evidence of statement from Resident #31 including details of the incident. There was discrepancy in Resident #48 statement and the investigation. The investigation indicated Resident #48 was not in her room on [DATE], however Resident #48's statement indicated he was in her room and retrieved tissues from the nurse for the resident. The female resident were interviewed but the statements only asked if they have been touched or felt uncomfortable by a male resident. There was no evidence if residents who reside around Resident #31's room was interviewed to see if they had heard or seen anything on [DATE]. Interview on [DATE] at 10:22 A.M., with Resident #48 revealed no concern regarding abuse. The resident did not mention the allegation against him. Resident #48 had a facility badge on and reported he volunteered a lot because he can't sleep. Resident #48 reported he helps paint, helps in activities, and any type of maintenance work. He worked maintenance in the past. The resident was ambulatory in wheelchair and was observed all over the facility and outside. Interview on [DATE] at 1:53 P.M., with Resident #6 revealed Resident #48 has asked her to go to bed with him several times in the last three months. Resident #6 indicated she had reported her concerns to staff already. Resident #6 reported she doesn't feel unsafe around the resident, but his statements were getting old. Interview on [DATE] at 4:44 P.M. with Administrator and DON revealed they had one more day to complete the investigation regarding Resident #31 and Resident #48, however they provided what information they had collected thus far. The Administrator confirmed there was no interview with Resident #31 due to it was difficult to communicate with her and she did not have a copy of the emergency room report. The Administrator and DON denied any negative interviews from residents and provided the residents interviews to the surveyor. The surveyor reported she had interview with Resident #6, and she reported an incident that involved Resident #48 as well. The DON retrieved a statement from her office that was not provided to the surveyor. The statement was from Resident #6. The Administrator reported he was not aware of the statement until the surveyor had asked for copies of the investigation and there were two statements that needed followed up on. He was originally told all the statements were negative for abuse. Resident #48 has not been monitored, however was educated on staying out of female rooms. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated ,d+[DATE] revealed It was the facility's policy to investigate all alleged violation of abuse, neglect, exploitation, and mistreatment of a resident, or misappropriation of resident's property. Facility staff should immediately report all such allegations to the Administrator and the State Agency in accordance with the procedures in this policy. Residents interested family members, or other persons may contact any member of the administration or the facilities nursing staff at any time with the concerns relating to abuse, neglect, exploitation, or misappropriation. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of the resident's belongings or money without the consent. Abuse was defined as willful (the individual must have acted deliberately) infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Sexual abuse was non-consensual sexual contact of any type with a resident. The facility should take action to protect the resident and preventing access to the resident during the investigation. The Administrator or designee would notify the state agency of alleged violation as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known to the staff member. Once the Administrator and state agency are notified, an investigation of the allegation violation would be conducted. The investigation should include interview from the resident, the accused, and all witness. This deficiency represents non-compliance investigated under Master Complaint Number OH00138950 and Complaint Number OH00136553.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, review of shower documentation, policy review, and interviews the facility failed to ensure Resident #65 received showers per his preference. This affected one (#65) of three residents reviewed for showers. Findings included: Record review revealed Resident #65 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including clostridium difficile (C-diff), muscle weakness, adult failure to thrive, and needs assistance with personal care. The resident was discharged again to the hospital on 01/24/23 and readmitted [DATE]. Review of Resident #65's admission Minimum Data Set (MDS) dated [DATE] revealed the resident and staff section of the resident preferences was blank. Review of Resident #65's quarterly MDS dated [DATE] revealed the resident required one-person physical assist with bathing and two-person extensive assist with personal hygiene and dressing. Review of Resident #65's activity of daily living (ADL) plan of care dated 11/18/22 revealed the resident was dependent on staff for bathing and staff would assist as needed with daily hygiene and would assist with showering residents as per facility policy weekly. Review of Resident #65's ADL task/shower documentation dated 01/12/23 to 01/24/23 revealed no evidence the resident received a shower. Interview on 01/30/23 at 9:41 A.M., with Resident #65's wife and daughter and the Director of Nursing (DON) present revealed the resident was told he could not have a shower since he was diagnosed with C-diff. Night shift staff had been giving him a bed bath, but the resident would really like a shower at least twice a week if not more. The DON told the family Resident #65 should have been getting a shower. The staff would just have to take him last to the shower room and clean the shower afterward with bleach. Interview on 01/30/23 at 3:15 P.M., with anonymous Staff Member #102 confirmed residents who were diagnosed with C-diff only received bed baths. Interview via email on 02/09/23 at 11:04 A.M., with the DON verified findings and said she would have staff offer the resident a shower today. Review of the facility's policy titled Personal Care Procedure date 07/2018 revealed it was the facility's policy to assist in care and hygiene to each resident based on their individual status and needs. Shower may be given at any time the resident chooses. A shower may only be necessary 2-3 times per week if the resident chooses this. A bed bath should be given on days a resident doesn't get a shower per their preferences. Residents who are incontinent of stool may need to be given personal hygiene more than one time a day. Staff are to document refusals and care provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00136553.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, review of the activity schedule, observation, interviews, and policy reviews revealed the facility failed to ensure cognitively impaired residents received activities per plan of care, evaluate resident's activities needs, offer activities at varied times (evening), encourage resident to participate, and offer activities to meet the resident's cognitive needs. This affected three (#44, #55, and #59) of three residents reviewed for activities and resided on the facility's previous memory care unit. The facility census was 74. Findings included: 1. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including dementia, heart failure, and depression. Review of Resident #44's significant Minimum Data Set (MDS) dated [DATE] revealed the resident activity preference was not conducted due to the resident was not interviewable. The staff section was all answered No Review of Resident #44's activity plan of care initiated on 11/02/22 revealed the resident needed encouragement to participate in activities of interest. The resident required dependence of staff for activities, cognitive stimulation, and social interaction due to dementia. He enjoyed watching television and visiting with others. Interventions included one to one room visits, assist, encourage, and escort to activities of choice, and turn on TV, music in room to provide sensory stimulation. Review of Resident #44's activity evaluation dated 11/03/22 revealed the resident activity preferences included card/games, watch television, and socialize. The resident requires strong encouragement to participate as tolerated. Review of Resident #44's activity documentation dated 01/11/23 to 02/08/23 revealed the resident had only attended one activity. He refused bingo three times, television once, church service once, and exercise once. Review of Resident #44's fall documentation dated 11/14/22 to 01/31/23 revealed the resident had sustained 17 falls. Observations of Resident #44 during the survey timeframe (01/25/23-02/08/23) revealed no evidence the resident participated in activities. The resident was noted wandering around the facility, sitting at nurses' station, or the nursing staff had the resident follow them around as they administered medication. There was no evidence staff encouraged the resident to attend activities. 2. Review of medical record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety, and major depression. Review of Resident #55's annual MDS dated [DATE] revealed the resident activity preference was not conducted due to the resident was not interview able and the staff section indicated the resident liked music and group activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #55's activity plan of care initiated 12/28/18 revealed the resident required dependence on staff for activities, cognitive stimulation, and social interactions related to cognitive deficits. Intervention included all staff to converse with resident while providing care, assure the resident attends activities compatible with physical and mental capabilities, invite resident to activities, and provide resident with materials for activities. Review of Resident #55's elopement plan of care dated 12/01/21 revealed an activity program would be developed to divert attention and meet individual needs. Review of Resident #55's activity evaluation revealed no evidence an evaluation had been completed. Review of Resident #55's activities documentation dated 01/11/23 to 02/08/23 revealed no evidence the resident had attended any activities. The resident had refused to go to bingo three times, television once, and church once. Observation of Resident #55 during the survey timeframe (01/25/23 - 02/08/23) revealed the resident was wandering the hallways, until 02/01/23 when she was placed on one on one supervision due several attempts to elope from the facility over the weekend. There was no evidence the resident was encouraged to attend activities. 3. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including anxiety, depression, alcohol induced dementia, and schizoaffective disorder. Review of Resident #59's annual MDS dated [DATE] revealed music and participating in his favorite activities were very important to him. Review of Resident #59's activities plan of care (revised on 09/18/22) revealed the resident required dependence of staff for activities, cognitive stimulation, and social interaction related to cognitive deficit, behaviors, and anxiety. The resident enjoys one on one conversation, watching television, and resting. The resident was a night owl. Interventions included all staff to converse with care, invite to activities, one on one bedside in room visits, and provide activities which do not involve overly demanding cognitive tasks. Review of Resident #59's activity evaluation revealed no evidence an evaluation had been completed. Review of Resident #59's activities documentation dated 01/11/23 to 02/08/23 revealed no evidence Resident #59 had attended any activities. Th resident refused bingo three times, television once, church once, and exercise once. Observation of Resident #59 during the survey timeframe (01/25/23 to 02/08/23) revealed the resident was in his room asleep. The resident woke up for meals and then straight back to bed. There was no evidence the resident was encouraged to attend activities. Observation on 01/25/23 at 8:10 A.M., revealed Resident's #44, #55, and #59 were on the previous memory care unit that had been recently closed in December, 2022. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an anonymous complaint dated 02/06/23 revealed concerns the residents that resided on the previous memory care unit were not receiving activities or encouraged to attend activities. Review of January 2023 and February 2023 activities calendars revealed in January 2023 activities were offered 9:00 A.M. to 1:00- 2:30 P.M. There was no evidence of evening activities being offered. The schedule was the same every Sunday. At 10:00 A.M. one on one activity, 11:00 A.M. patio time, and church at 1:00 P. M. Monday to Saturday was the same as well except for the 2:30 P.M. activity varied daily, however this activity was the same week after week. At 9:00 A.M. was daily chronicle, 10:00 A.M., one on one on Monday and other days was happy hour, 11:00 A.M., patio time, and at 2:30 P.M., it was bingo, art, volleyball, and movie weekly. February 2023 activity schedule was reviewed. On Sundays at 10:00 A.M., was happy hour, 11:00 A.M. and 2:00 P.M. was patio time, 1:00 P.M. and 2:30 P.M. church. Monday to Saturday at 10:00 AM was happy hour, 11:00 A.M., patio time, 1:00 P.M. exercise club, 2:00 P.M. patio time again, and 2:30 P.M. activity rotated from bingo, volleyball, craft, volleyball, bingo, move and snacks and then repeated every week. There was no evidence evening activities were offered. Interview on 02/07/23 at 4:27 P.M., with Social Service Designee (SSD)/Activity Director (AD)#104 verified she had no documented evidence Resident's #44, #55, and #59 had participated in activities. The SSD reported she was hired to be the activities director and then after a month they added SSD to her job duties. There was an activity assistant (AA #64) that was not working her scheduled times and she was in the process of being terminated. The activity aides do not have access to the electronic medical records to access activity assessment/evaluations, plans of care, or document activities. The SSD was responsible for charting all activities and can't believe she had never caught the residents were not attending activities before this. The SSD provided a new one on one schedule that she was going to implement immediately to include Residents #44, #55, and #59. Interview on 02/08/23 at 8:29 A.M., with Resident #6 verified she helps with all activities and Resident's #44, #55, and #59 never attend activities. Per Resident #6, Activities Aide (AA) #64 never encouraged residents to attend activities and she had removed extra tables limiting the number of residents that could attend activities. Resident #6 reported it was usually the same people that attend activities. Interview on 02/08/23 at 9:11 A.M., with State tested Nurse's Aide (STNA) #50 revealed Resident #44, #55, and #59 are not provided appropriate activities to meet their cognition needs. The activities director was trying to perform two jobs and the social service job only was enough for one person. Interview on 02/08/23 at 10:24 A.M., with STNA #25 and #40 revealed Residents #44, #55, and #59 are not encouraged to attend activities or participate in activities. If a resident can't take themselves to activities, then they don't go. Per STNA #25 and #50, on Sunday the only reason residents were encouraged to go to church was because the people from the church are related to one of the staff members. Interview on 02/08/23 at 10:49 A.M., with Director of Nursing and Corporate Nurse #55 revealed they were not aware of the concerns with activities. Corporate Nurse #55 verified Residents #55 and #59 did not have activity assessment/evaluation completed and there was no evidence the residents attended or refused activities in the last 23 days. (continued on next page)

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	365770	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Activity Program dated 11/2020 revealed the facility provides activity programs that are designed to meet the needs of the resident and are available on a daily basis. Various activities are provided to meet the needs of residents with range of cognitive and physical level of functioning. Unless care planned, the facility's goal was to provide 2-3 activities, group or one on one as tolerated by residents. The facility provides activities that reflect the choices of the residents, offered at various hours including morning, afternoon, evening, holidays, and weekends. Assistance is provided to residents to attend the activities of their choices with their individual medical and safety abilities. This deficiency represents non-compliance investigated under Complaint Number OH00136553.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of hospital records, review of the facility policy and procedures related to change of condition, diagnostic testing services, culture and sensitivity lab results, and physical assessment and interviews with staff and Resident #65's family, the facility failed to provide timely and adequate care and treatment for Resident #65 who exhibited acute changes in condition with resident/family requests for hospitalization . This resulted in Immediate Jeopardy with serious life-threatening harm beginning on 12/23/22 when Resident #65, who was symptomatic of a C-Diff infection was not tested for the infection as ordered by the physician, properly treated or transferred to the hospital until 01/02/23 where he was admitted for nine days for treatment of C-Diff, colitis due to Clostridial Difficile, bilateral effusion, urinary tract infection, acute on chronic renal failure, elevated troponin, and adult failure to thrive. The Immediate Jeopardy continued 01/24/23 when Resident #65 experienced a second acute change/decline in condition and the resident, and his family requested the resident be transferred to the emergency room for evaluation and treatment. Registered Nurse (RN) #39 denied the resident's request to be transferred, failed to identify the significant change in condition, and failed to notify the resident's physician resulting in a delay in treatment until Resident #65's eventual transfer to the hospital (four hours after the change in condition and request by the resident) where he required aggressive critical care treatment including intravenous (IV) insulin push and drip, IV fluids, BiPap (respiratory care) and vasopressor medication and was transferred to the intensive care unit (ICU) for continuous monitoring and treatment of septic shock, diabetic ketoacidosis (DKA), acute respiratory failure related to COVID-19, hyperglycemia (blood sugar greater than 700) acute on chronic renal failure and dyspnea. In addition, a concern that did not rise to the level of Immediate Jeopardy was identified related to the facility's failure to appropriately and timely treat Resident #56's post surgical right wrist infection. Actual Harm occurred to Resident #56 on 01/07/23 when the facility was notified of the final culture results identifying a right wrist surgical wound infection and the facility failed to notify the resident's physician of the results thereby delaying treatment of the surgical wound for two days resulting in worsening of the infection requiring hospitalization and treatment with IV antibiotics. This affected two residents (#65 and #56) of three residents reviewed for change in condition. The facility census was 74. On 02/02/23 at 4:34 P.M., the Director of Nursing (DON), Regional Director of Clinical Operations #55, and Assistant Director of Nursing (Registered Nurse (RN)) #59, were notified Immediate Jeopardy began on 12/23/22 when the facility failed to timely identify and provide medical treatment to Resident #65 following an acute change in his medical condition resulting in a nine-day hospitalization . Following the resident's return, on 01/24/23 Resident #65 exhibited nausea and vomiting and requested to be transferred to the emergency room , however, RN #39 declined to send the resident and did not notify the physician. Resident #65 was sent to the hospital four hours after he requested additional evaluation and treatment at the hospital where he was admitted to the intensive care unit. The Immediate Jeopardy was removed on 02/06/23 when the facility implemented the following corrective actions: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/02/23 at 4:07 P.M. Medical Director (MD) #56 was notified by the Director of Nursing (DON)/designee Resident #65 stool cultures were not obtained on 12/23/22 and 12/30/22 which contributed to the resident's hospitalization . In addition, MD #56 was notified Registered Nurse (RN) #39 had not afforded Resident #65 the right to timely transfer to the emergency roiagnom on [DATE] and 01/24/23 per the resident/family request. MD #65 was also notified of the facility's plan of correction and agreed with the plan moving forward. On 02/02/23 (no time identified)- the facility identified that all 72 residents had the potential to be affected by labs not being completed timely, physical assessment not being completed and notification of change to physician not being completed. On 02/02/23 at 5:41 P.M. Regional Director of Clinical Operations #55 reviewed the facility notification of change and culture and sensitivity lab results policies with no changes made. On 02/02/23 at 5:45 P.M. RN #3, RN #43 and LPN #60 completed physical assessments for all 72 residents to identify any changes in condition and notification was made to the physician of any noted changes. On 02/02/23 at 6:00 P.M. Regional Director of Clinical Operations #55 reviewed resident discharges to the hospital from 12/23/22 to 02/02/23 for proper communication/notification. On 02/02/23 at 6:40 P.M. the DON educated RN #39 on following policies for changes in condition, lab procedures and resident/family requests. On 02/02/23 at 6:40 P.M. the DON was educated by Regional Director of Clinical Operations #55 to review the facility 24-hour report and Order Listing report identifying any changes of conditions with notifications that need completed and following up on all labs ordered to ensure they were completed timely. On 02/02/23 at 8:30 P.M. the DON and ADON #59 reviewed all labs ordered from 12/23/22 to 02/02/23 to ensure labs were obtained. As a result of the review, laboratory testing that had not been completed was identified. Laboratory testing for Resident #41, Resident #43, Resident #38, and Resident #65 were obtained as needed following the audit/review. On 02/02/23 at 9:05 P.M. Resident #65 was readmitted to the facility. A head-to-toe assessment (including vital signs), skin observation, oral assessment, neurological assessment, respiratory assessment, cardiovascular assessment, GI/GU assessment, pain assessment, mobility and psychosocial assessment were completed by Registered Nurse (RN) #57. Beginning on 02/02/23 the DON/designee provided staff education via in person and/or via telephone related to notification of changes, performing an assessment, and obtaining labs as ordered. The facility identified ten RN's and nine LPN's were educated. Seven (7) staff members did not receive the education (RN #5, LPN #19, LPN #21, RN #26, RN #30, RN #31, and RN #42) and are not permitted to work a shift until education had been completed by the DON/designee. Beginning on 02/02/23 (no time identified) the DON/designee implemented a plan for new hire licensed nurses to be educated on notification of changes, obtaining labs as ordered and performing an assessment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 02/03/23 (no time identified) the facility implemented a plan for the DON/designee to audit the 24-hour report daily and Order Listing report to monitor for change in resident condition, labs ordered, and notification daily for two weeks, then three times a week for two weeks. This would monitor to ensure labs ordered were being completed timely and changes with residents included notifications completed timely. The facility identified changes in condition could include the following: Accidents Resulting in injury. Potential to require physician intervention. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: Life-threatening conditions, or Clinical complications. Circumstances that require a need to alter treatment. This may include: New treatment. Discontinuation of current treatment due to: Adverse consequences. Acute condition. Exacerbation of a chronic condition. A transfer or discharge of the resident from the facility. A change of room or roommate assignment. A change in resident rights. Beginning on 02/03/23 (no time identified) the facility implemented a plan for the DON/designee to complete chart audits on three (3) residents randomly weekly for four weeks to ensure labs ordered were completed timely, notification was completed and assessments for residents were properly documented with notifications of change completed if applicable. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/06/23 from 9:10 A.M. and 9:17 A.M. interviews with LPN #2, LPN #38, LPN #60, and RN #59 revealed the staff could not recall the education they were provided on 02/02/23. LPN #2 reported she was educated on elopements and change of condition was all she could recall. LPN #38 reported she was educated on elopements and couldn't think of anything else. LPN #60 reported she was educated on elopements and transfers. She could not recall being educated on notification of change or laboratory testing. RN #59 reported she could not recall what she was educated about and asked LPN #2 and #60 if they could recall. On 02/06/23 at 12:35 P.M. interview with the DON and Regional Director of Clinical Operations #55 verified all licensed nurse staff were not knowledgeable on the education they were supposed to have received on 02/02/23. Based on the staff's lack of knowledge, Regional Director of Clinical Operation #55 indicated additional re-education would be completed on this date. On 02/06/23 from 3:46 P.M. to 3:48 P.M. interview with RN #59, RN #61, LPN 38, and LPN #60 revealed they were acknowledgeable on notification of changes, laboratory testing, and physical assessments. Beginning on 02/09/23 the facility identified all audits would be brought to the facility Quality Assessment Performance Improvement (QAPI) meeting and reviewed beginning with a meeting scheduled for 02/09/23. Although the Immediate Jeopardy was removed on 02/06/23, the facility remained out of compliance at Severity Level 3 (actual harm that is not Immediate Jeopardy) due to the identified deficiency for Resident #56 and as the facility was in the process of implementing their corrective action plan and monitoring related to the Immediate Jeopardy findings. Findings Include: 1. Review of Resident #65's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including acute osteomyelitis in left ankle and foot, gastric reflux disease, heart failure dysphagia, anxiety, type two diabetes, and benign prostatic hyperplasia. Review of Resident #65's admission Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10 which reflected moderate cognitive impairment (score 8-12 moderate; score 13-15 intact cognition). The assessment also reflected the resident was always incontinent of bowel. Record review revealed a plan of care, initiated 11/14/22 related to bowel and bladder incontinence. The care plan did not include any interventions related to monitoring the resident's bowel function, identification of changes or physician notification. A second plan of care, initiated 11/19/22 revealed the resident was at risk for hyperglycemia. Interventions included to be alert for signs/symptoms of hyperglycemia including increased lack of appetite, fatigue, abdominal cramps, nausea/vomiting, and blood glucose greater than 200. Interventions included laboratory testing as ordered. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nurse Practitioner (NP) note, dated 12/23/22 revealed staff requested the resident be seen for frequent loose stools for several days and occasional nausea and poor appetite. The resident denied diarrhea and vomiting, however had loose stools. The NP provided new orders for stool cultures and the medication Questran (bile acid sequestrant) as needed and noted to continue Zofran medication for nausea. Review of the nursing progress notes for this time period revealed no additional assessment, monitoring or notation identifying or addressing these symptoms the resident was having at that time. Record review revealed no evidence the stool culture ordered on 12/23/22 was obtained by the facility. Review of Resident #65's nursing progress notes dated 12/23/22 to 01/01/23 revealed Resident #65 was alert, but had impaired decision making, normal breathing, and was incontinent of bowel and bladder. The progress notes failed to contain any additional follow up or evidence of monitoring related to the NP note dated 12/23/22. Review of a progress note from Physician #56, dated 12/31/22 revealed the resident's daughter had requested the resident be seen due to the resident having diarrhea and weakness. New orders for laboratory testing, including a complete blood count (CBC), complete metabolic profile (CMP) and the stool culture was already ordered (12/30/22). Record review revealed no evidence the stool culture ordered on 12/30/22 was obtained by the facility. The next nursing progress note (following the physician note on 12/31/22), dated 01/02/23 at 8:00 P.M. and authored by RN #39 revealed Resident #65 complained of persistent nausea and had emesis times two. RN #39 documented the resident was given medication for nausea with not much relief. Resident #65's wife and daughter were at the bedside and insisted the resident be sent to the emergency room for an evaluation for nausea and vomiting. The progress note indicated Resident #65's vital signs were within normal limits. The resident's blood sugar was elevated at 408 milligrams per deciliter (mg/dL) and a COVID-19 swab was negative. A nursing progress note, dated 01/02/23 at 9:15 P.M. and authored by RN #39 revealed the nurse made the physician on-call service aware of Resident #65's nausea and vomiting that occurred on this date. The physician on-call service gave orders to start the mediation, Protonix (a medication to reduce stomach acid) 40 milligrams (mg) twice daily, a kidney ureter bladder (KUB) x-ray, and noted if the family insisted to send Resident #65 to the emergency room . A nursing progress note dated 01/02/23 at 9:20 P.M. and authored by RN #39 revealed Resident #65's family wanted the resident sent to the emergency room . On 01/02/23 at 9:45 P.M. transportation arrived to take the resident to the emergency room . Review of Resident #65 hospital note, dated 01/02/23 revealed the resident was admitted to the hospital with C-Diff, colitis due to Clostridial Difficile, bilateral effusion, urinary tract infection (UTI), acute on chronic renal failure, elevated troponin, and adult failure to thrive. Following treatment, the resident was readmitted to the facility on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of nursing progress notes dated 01/12/23 to 01/23/23 revealed Resident #65 continued to have loose stools and swelling in the right abdomen that would come and go. NP #65 was aware and ordered ultrasound on 01/13/23. On 01/15/23 at 4:50 P.M., the abdomen ultrasound was completed at the facility. Review of the abdominal ultrasound, dated 01/15/23 revealed the resident had 2.2 centimeter (cm) by 2.3 cm area suspicious for hernia in the right lower quadrant. Review of a nursing progress note dated 01/24/23 at 7:00 P.M. and authored by RN #39 revealed Resident #65's wife stated the resident had some emesis. The resident's wife wanted the resident sent to the emergency room . The note revealed RN #39 administered the medication Zofran, assessed the resident's lungs (which were clear) and documented will continue to monitor. There was no documented evidence the RN assessed the resident's vital signs, including temperature, blood pressure, pulse, or oxygen saturation at that time. In addition, record review revealed no evidence the physician or on call services were notified of Resident #65's family request to send the resident to the emergency room for evaluation and treatment or Resident #65's emesis. There was no documented evidence RN#39 assessed Resident #65 after 7:00 P.M. Review of a nursing progress note dated 01/24/23 at 11:05 P.M. and authored by LPN #52 revealed she was called to Resident #65's room by the State tested Nursing Assistant (STNA). Resident #65 was vomiting, shaky, stated he had chills and was assessed to have adventitious lung sounds with rhonchi in his upper lobes. The resident was assessed to have an elevated temperature of 99.5 degrees Fahrenheit and requested to go to the emergency room for evaluation. The resident's wife was called at this time and stated she wanted the resident transferred to the hospital for evaluation. The emergency squad was called for transport, and report was called to the hospital. Resident #65's wife was at the facility when the resident left. Review of Resident #65's hospital notes, dated 01/24/23 revealed the resident was seen in the emergency room at 11:55 P.M., was unstable and required constant supervision by the physician for 45 minutes. The resident was placed on a BiPap (respiratory machine) secondary to respiratory distress. The resident's blood glucose/sugar level was greater than 700 (hyperglycemic) requiring an IV insulin push followed by an insulin drip. The resident required four liters of normal saline (fluids) due to being in septic shock with depressed renal perfusion as well as hypovolemia from nausea and vomiting and poor intakes. The resident was transferred to ICU for close observation and aggressive management as mentioned. The resident's admitting diagnoses were diabetic ketoacidosis (DKA), acute respiratory failure due to COVID-19, hyperglycemia, acute and chronic renal failure, dyspnea, acute confusion, and severe sepsis. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/30/23 at 9:41 A.M., interview with Resident # 65's wife and daughter revealed they had concerns with the resident's care and treatment at the facility. Resident #65's family requested the DON and ADON (RN) #59 be present for the interview. Resident #65's family members reported they had requested Resident #65 be transferred to the emergency room twice and both times RN #39 refused to send the resident. Both times RN #39 told Resident #65 and family the resident just needed something for nausea. Per Resident #65's family, the first incident was on 01/02/23, however RN #39 eventually called the on-call provider, and the provider gave permission to send the resident to the emergency room if the family insisted, but indicated they were told the provider just wanted to try something stronger for the resident's nausea. Resident #65's family insisted the resident be sent to the emergency room and RN #39 did make the arrangements. The hospital told Resident #65's family it was a good thing they got him there when they did because he (Resident #65) was almost dead due to his body being filled with infection. Resident #65's family also indicated the resident was ordered stool testing for C-Diff prior to being sent to the hospital and it was never completed. The family was told the first specimen was lost and the second was still in the refrigerator and was never sent. Resident #65's family reported a second incident with RN #39 occurred on 01/24/23. RN #39 refused to send Resident #65 to the emergency room upon resident/family request. The resident's wife reported she knew the resident was in bad shape when he asked to go to the emergency room . This time, RN #39 did not call the physician. The resident deteriorated and was sent to the emergency room a few hours later by another nurse who took over the resident's care at 10:00 P.M. When Resident #65 was admitted to the hospital on 01/24/23, the family revealed he was diagnosed with COVID-19, a bowel infection, dehydration, and C-Diff. Resident #65 remained in the hospital as of 01/30/23 at 9;41 A.M. (the date and time of this interview). On 01/31/23 at 1:26 P.M. interview with STNA #50 revealed on 01/24/23 Resident #65 was fine during the day and then at dinner time he refused his dinner and had vomited. Resident #65's wife reported the resident had consumed water and milk and it caused him to be sick. Resident #65's wife had voiced concerns to STNA #50 that RN #39 refused to let her husband go to the emergency room . During the interview, STNA #50 reported there was an incident prior to 01/24/23 when Resident #65 was exhibiting signs and symptoms of C-Diff and he was not placed in isolation until he returned from the hospital (on 01/11/23). Resident #65 had orders for stool cultures, however they were never sent to the laboratory for testing. Per STNA #50, there had been complaints the on-call (physician) services don't want to send residents to the emergency room . On 01/31/23 at 3:17 P.M. interview with STNA #40 revealed Resident #65's family had voiced concerns regarding RN #39 refusing to send Resident #65 to the hospital after the family had demanded he be sent to the hospital. Resident #65's family reported there were two incidents RN #39 refused to send the resident out upon request of the family and resident. STNA #40 reported she was the one who had reported the resident was having loose stools to the nurse. The STNA revealed Resident #65 was quiet and sleeping a lot which was a change of condition for him. At first Resident #65's stools were just loose then they were more frequent and had an odor. The STNA indicated there were two stool samples collected for Resident #65, however the samples were never sent to the laboratory for testing. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/31/23 at 5:57 P.M. interview with RN #39 revealed she could not remember much about Resident #65's first hospitalization on [DATE]. RN #39 thought maybe Resident #65's family wanted to have the resident sent out, but stated she was passing medications at that time. Per RN #39, she did call the nurse practitioner (NP) and indicated the NP wanted to treat Resident #65 in-house, but stated if the family really wanted the resident sent out then she (RN #39) could do so. Per RN #39, on 01/24/23, she only worked 6:00 P.M. to 10:00 P.M., that night. The aides came to her and reported she was needed in Resident #65's room. The resident had vomited and was nauseated. RN #39 recalled she had offered Resident #65 Zofran for the nausea. She listened to the resident's lungs, and they were fine. RN #39 touched the resident's head and said she didn't think he was running a fever. RN #39 reported she doesn't think she checked the resident's temperature at that time with a thermometer. Per RN #39, Resident #65's wife wanted the resident sent to the hospital and RN #39 told her there was no reason to send him and to let the Zofran work. Resident #65's wife also wanted a chest x-ray; RN #39 told the resident's wife there was no need for a chest x-ray. Resident #65's wife told RN #39 If it turns into pneumonia, it is back on you. RN #39 checked the resident's blood sugar and gave him his scheduled insulin. RN #39 did not contact the physician regarding Resident #65's condition and gave report of the incident to LPN #52 at 10:00 P.M., when the LPN took over her shift. On 01/31/23 at 6:30 P.M. interview with LPN #52 revealed she had worked beginning on 01/24/23 at 10:00 P. M. and during report, RN #39 noted Resident #65 had vomited once and she checked his lung sounds and was monitoring him. RN #39 had reported the family wanted the resident sent out (to the hospital), but she (RN #39) did not send Resident #65 out and wanted to know LPN #52's opinion on what she should have done. LPN #52 told RN #39 she would have sent Resident #65 out to the hospital if the family requested. Shortly after report, staff reported to LPN #52 that Resident #65 had vomited again. Per LPN #52, upon her assessment, Resident #65's lungs were raspy, and he was chilled. LPN #52 used her nursing judgement and sent Resident #65 to the hospital. Resident #65's wife had voiced concerns she had requested the resident be sent out earlier and the nurse (RN #39) refused to send him. Per LPN #52, Resident #65 now had a fever and she thought he had aspirated on his vomit causing his lungs to be raspy. LPN #52 knew with Resident #65's history of sepsis and comorbidities she needed to get him sent out to the hospital fast. LPN #52 confirmed she did not check Resident #65's blood sugar or call the physician to approve Resident #65's transfer to the hospital. On 02/02/23 at 9:30 A.M. interview with the DON and Regional Director of Clinical Operations #55 verified Resident #65's stool cultures were not obtained per order on 12/23/22 or 12/30/22 and Resident #65 was hospitalized from 01/02/23 to 01/11/23 for diagnosis and treatment of C-Diff. In addition, an interview on 02/06/23 at 1:20 P.M. with Regional Director of Clinical Operations #55 verified Resident #65's laboratory testing ordered on 12/31/22 had not been obtained as ordered. Review of the facility policy titled Notification of Changes dated 10/01/22 revealed the facility would promptly inform the resident, consult the resident's physician; and notify, consistent with his or her authority, the resident's representative when there was a change requiring notification. The facility is required to inform the residents of his/her rights upon admission and during the resident's stay. (continued on next page)

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	365770	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled Diagnostic Testing Services dated 10/01/22 revealed the facility would provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with State and Federal guidelines. The facility would maintain a schedule of diagnostic tests in accordance with the physician orders. No diagnostic test will be performed without specific physician, physician assistant, nurse practitioner or clinical nurse specialist orders in accordance with State law to include scope of practice law. Qualified nursing personnel will receive and review the diagnostic teste reports and communicate the results to the ordering physician within 24 hours of receipt unless that report results fall outside the clinical reference ranges and require immediate attention at which time the physician would be notified upon receipt. Documentation of the test results, date/time of Physician notification would be maintained in the resident's clinical records. Review of the facility undated policy titled Culture and Sensitivity Lab Results revealed culture and sensitivity refers to laboratory testing of various specimens for the identification of pathogens and the susceptibility of those pathogens to treatment with antibiotics. Laboratory testing shall be in accordance with providers orders and current standards of practice. Specimens for culture and sensitivity testing shall be collected and transported in accordance with facility and laboratory policies for collection and transport. Review of the facility undated policy titled Validation Checklist Physical Assessment revealed the purpose of the checklist was to ensure the individual performing the physical assessment of the resident was doing so in accordance with current standards of practice. Assess all organ systems, verbalize which findings are abnormal and which ones require immediate physician notification. Notify physician, where applicable, and document findings appropriately. 2. Review of the medical record for Resident #56 revealed an original admitted [DATE] and re-admitted [DATE]. Diagnoses included acute pain related to trauma, laceration of the spleen, fractured shaft of right femur, open [NAME] fracture, fracture distal end of right radius, multiple rib fractures, and low back pain. Review of nursing progress note dated 01/04/23 at 12:49 P.M., revealed Resident #56 reported that her right wrist had a different pain to it. Upon observation of the right wrist, the pin site was red in color, swollen, and scant amount of yellow drainage noted. Resident stated that she doesn't receive pain medication in the middle of the night but once she wakes up her pain was out of control. The Nurse Practitioner (NP) #65 was notified of the residents' concerns and orders were given for the resident to receive scheduled Oxycodone 5 milligrams (mg) every hour, culture of pin site, apply ice to right wrist every two hours and as needed. Culture was collected at this time. Review of nursing progress note dated 01/05/23 at 10:23 A.M., revealed the wound culture was picked up by the lab. Further review of nursing progress notes dated 01/05/23 to 01/10/23 revealed no evidence of assessment of the right wrist wound, however on 01/09/23 the resident was ordered Augmentin Oral Tablet 875-125 MG (Amoxicillin & Pot Clavulanate) give 1 tablet by mouth two times a day for wound infection for seven days. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/11/23 the nursing note indicated the nurse was summoned to Resident #56's room. The resident was holding her right wrist in the air and stated that she was concerned about her wrist. The right wrist was visually swollen, redness noted to bilateral side of the incision line, two centimeter distal incision note to be an early eruption starting. No drainage noted at the moment. The NP #65 was notified and recommended resident be transferred back to the university hospital where she would have better continuity of care. The resident and spouse agree, and spouse will transport resident. Review of Resident #56's wound culture results dated 01/05/23 revealed on 01/07/23 the final culture indicated the organism was staphylococcus aureus (moderate) and was sensitive to Augmentin. Review of Resident #56's Medication Administration Records (MAR) and orders dated 01/09/23 revealed the resident received one dose of Augmentin on 01/09/23, two doses on 01/10/23, one dose on 01/11/23, and one dose was sent with the resident on 01/11/23. Review of Resident #56's hospital discharge records dated 01/17/23 revealed on 01/11/23 a [AGE] year old female presented with pain, swelling, and infection to a post-surgical right wrist incision site. The redness and pain had increased over the last two weeks and now progressed significantly to redness, pain, and purulent drainage. The resident was in a severe motor vehicle collision on 12/09/22 and sustained multiple fractures. Upon evaluation at the hospital on 01/11/23, Resident #56 did have significant white pus drainage to right wrist. The surgical site had a partial dehiscence with the distal one third of the wound with some serous drainage. The resident was diagnosed with cellulitis and possibly osteomyelitis that required admission to the hospital for intravenous Vancomycin and Unasyn antibiotic treatment. Interview on 01/25/23 at 12:30 P.M., with Resident #56 revealed she had reported to staff that her right wrist was infected, and they kept telling her it was just the healing process. The night nurse had removed the soft cast off the right wrist and the wrist was hot to touch and swollen. Licensed Practical Nurse (LPN) #2 cultured the wound, but she did not culture the wound correctly. Per Resident #56, LPN #2 had swabbed the outside of the wound and not inside the wound. After four or five days, the resident had not heard anything about the culture results so she had to track down her own culture results (the resident identified this meant that she had to keep asking staff multiple times to check on her lab results). The NP started her on antibiotics finally and after the 3rd day of antibiotics the swelling and abscess was so bad she asked to go the hospital. The abscess ruptured at the hospital requiring intravenous treatments and she was on the hospital from 01/11/23 to 01/27/23. Interview on 02/15/23 at 11:45 A.M. via email with the DON revealed she did not have any documented evidence why there was delay in Resident #56's treatment to the right wrist. The DON confirmed Resident #56's wound culture was collected on 01/04/22, sent to lab on 01/05/23, culture results were final on 01/07/23, however the resident was not started on treatment until 01/09/23. This deficiency represents non-compliance investigated under Master Complaint Number OH00138950 and Complaint Number OH00136553.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, review of fall investigation, observation, interviews, and policy review the facility failed to ensure fall interventions were in place per resident's plan of care and failed to ensure all falls were investigated. The facility also failed to ensure water temperatures were not greater than 120 degrees Fahrenheit and failed to provide adequate supervision to prevent elopements. This affected one (#44) of three residents reviewed for falls, 17 residents (#44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, and #60) of 17 residents that reside on the Southeast unit, and one resident (#55) of three residents reviewed for elopements. Findings included: 1a. Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including dementia, repeated falls, hypertension, depression, heart failure, muscle weakness, and difficulty walking. Review of Resident #44's nursing progress note dated 12/18/22 at 8:11 A.M., revealed the State tested Nurse's Aide (STNA) walked into Resident #44's room and the resident was noted to be on the floor. Resident #44 stated he dropped his tray and was trying to clean it up. A skin tear was noted to the right forearm. No other injuries were noted. Resident #44 was assisted up per staff and arm cleansed and dressed. Review of Resident #44's fall investigation revealed no evidence a fall investigation or neurological checks were completed on 12/18/22 after the resident sustained a fall per the nurse's note. Interview on 02/07/23 at 11:41 A.M., with Corporate Nurse #55 confirmed Resident #44's fall on 12/18/22 was not listed on the incident log, no evidence the fall was investigated, and no evidence an IDT note was completed. 1b. Review of Resident #44's fall plan of care initiated on 11/05/22 revealed the resident was high risk for falls related to poor cognition and safety awareness, wandering, and use of antidepressants. Intervention included dycem to wheelchair and hipsters as resident allows. Observation on 01/26/23 at 4:35 P.M., of Resident #44 with State tested Nurse's Aide (STNA) #25 revealed the resident did not have hipsters in-place or dycem in wheelchair. Review of anonymous complaint dated 11/22/22 revealed the caller's family member keeps falling and it was getting ridiculous. There weren't staff available to help the family member as needed. The falls always occur in the evenings or night shift on the weekends. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Fall Prevention Program dated 08/01/22 revealed each resident would be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Intervention would be to address unique risk factors measured by the risk assessment tool: medication, psychological, cognitive status, or recent change in function in functional status. Additional interventions as directed by the resident's assessment, including but not limited to assistive devices, increased frequency of rounds, sitter, and medication regimen review, low bed, alternative call system access, scheduled ambulation or toileting assistance, family/caregiver or resident education, or therapy services referrals. Interventions would be monitored for effectiveness and plan of care would be revised as needed. When a resident experiences a fall, the facility would assess the resident, complete a post-fall assessment, complete an incident report, notify physician and family, review residents plan of care and update it document all assessments and actions, obtain witness statements in case of injury, and start neuro checks for any witnessed fall or fall that involves the resident hitting their head. 2. Observation on 01/25/23 at 9:29 A.M., of water temperatures with the Maintenance Director (MD) revealed in room [ROOM NUMBER] (furthest room from hot water tank) the temperature in the resident's sink was 124.3 degrees Fahrenheit and room [ROOM NUMBER] (closer to the hot water tank) was 121 degrees Fahrenheit. The hot water tank was set at 140 degrees Fahrenheit. Temperatures were obtained and confirmed by the MD. Observation on 01/30/23 from 8:18 A.M. to 8:29 A.M. of water temperatures with Maintenance Assistant (MA) #108 revealed the water temperature in room [ROOM NUMBER] was 125.2 degrees Fahrenheit, room [ROOM NUMBER] was 128.3 degrees Fahrenheit, the shower room on Southeast was 125.7 degrees Fahrenheit, and room [ROOM NUMBER] was 120.4. The temperatures were obtained and confirmed by MA #108. The MA confirmed the water temperatures should have been between 110-120. Review of the facility room listing revealed the elevated water temperatures were only affecting those 17 residents residing on the Southeast unit of the facility: Residents #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, and #60. Review of the facility's policy titled Water Temperatures dated 12/2009 revealed tap water should kept within at temperature rang to prevent scalding residents. Water heaters that service residents' room, bathrooms, common areas, and tub/showers areas shall be set at temperatures of no more than 120 degrees Fahrenheit, the maximum temperature per state regulation. 3a. Record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, difficulty walking, psychosis, anxiety, depression, insomnia, and chronic lymphocytic leukemia. Review of Resident #55's progress notes dated 01/27/23, 01/28/23 and 01/29/23 revealed no evidence the resident was exit seeking, wandering, or eloped to an unsupervised area. Review of Resident #55's wander/elopement assessment dated [DATE] revealed Resident #55 was at high risk for elopement related to wandering behaviors and successful elopements. The resident also tries to tailgate visitors. A wander guard was put in-place. Intervention included to record, report, and observe any risk factor for potential elopements. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #55's quarterly Minimum Date Set (MDS) dated [DATE] revealed the resident had 1-3 days of wandering behaviors. Review of Resident #55's elopement plan of care dated 12/01/21 revealed the resident had a wander guard to reduce risk of elopement, an activity program would be developed to divert attention and meet individual needs, observe, and record any unsafe behaviors/risk of elopement and notify the physician. Review of Resident #55's behavioral documentation in the task tab dated 01/03/23 to 02/01/23 revealed the resident had wandering behaviors on 01/03/23, 01/07/23, 01/09/23, 01/11/23, 01/12/23, 01/13/23, 01/14/23, 01/16/23, 01/19/23, 01/20/23, 01/23/23, 01/25/23, 01/28/23. There was no evidence the resident was wandering on 01/27/23 or 01/29/23. In the behavioral documentation task tab there was no option staff could check indicating if the resident had exit seeking behaviors or elopement. Interview on 01/30/23 at 10:25 AM with Resident #56 revealed she was concerned with Resident #55's safety. Over the weekend (01/27/23, 01/28/23, and 01/29/23) Resident #55 had exited out the side door and it was approximately five minutes before staff came to address the sounding alarm. Interview on 01/30/23 at 11:00 A.M. and 12:12 P.M., with the DON confirmed she was not aware of any allegations that Resident #55 had eloped over the weekend. There was no evidence charted in the resident's medical record as well. At 12:12 P.M., the DON reported she had called some staff that worked over the weekend and confirmed Resident #55 had attempted to elope out the end of the hall and out of the main lobby doors. Staff reported they had told Resident #55's family when they were visiting on Sunday. The DON reported she was told the resident did not leave the facility property. Interview on 01/30/23 at 12:39 P.M., with Resident #55's daughter confirmed the facility did not call her to notify her Resident #55 was exit seeking or exited the building. On Sunday. Resident #55's daughter was visiting the resident with her sister and the resident was tearful. Resident #55's daughter had asked STNA #50 if her mom could have her as needed Ativan for her anxiety. The STNA reported that Resident #55 was better today because the last few days she had been very anxious and had eloped. Resident #55 was found out in the parking lot a few times. The first time she had followed a resident out the front door and the resident kept her safe until staff came and the second time Resident #55 had exited out the side doors several times as well. Resident #55's daughter reported since the facility had closed the secured unit due to, they could not justify having one staff member on the secure unit for six residents per the DON, Resident #55's behaviors had escalated. Interview on 01/31/23 at 1:26 P.M., with STNA #50 revealed she had worked Friday, Saturday, and Sunday (01/27/23, 01/28/23, and 01/29/23). Resident #55 was exit seeking and the resident was aware if she held the door for 15 seconds the doors will open. Resident #55 was found exiting out the side doors, which lead out into a secured gated area and Resident #55 had followed a resident out the front door once. Interview on 01/31/23 at 3:17 P.M., with STNA #40 revealed on Friday (01/27/23) Resident #55 had the glaze in her eyes. Staff were busy, however they were trying to watch her the best they could. On Friday (01/27/23) she walked out the front door with a group of visitors and was found in the parking lot by a resident, however earlier that day she had exited out the side doors into a gated area. The nurse went to get her due to the alarm was sounding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On Saturday (01/28/23) Resident #55 had exited out the side door twice before lunch and exited out the front doors once. On Sunday (01/29/23) Resident #55 was exit seeking, however she never made it outside. Resident #55's family was visiting Sunday and asked for an Ativan to help her anxiety. Interview on 01/31/23 at 5:15 P.M., with Resident #36 confirmed Resident #55 had followed him outside on Saturday (01/28/23). The resident reported he tried to get Resident #55 to come back inside but she wouldn't come back in. He went inside and got the transport lady and she went and got staff to come out and assist the resident back inside. Interview on 02/01/23 at 12:49 P.M., with the DON revealed she was still investigating Resident #55's elopements and exit seeking behaviors. The DON confirmed Resident #55 had exited the front door twice and the side doors a few times per the interviews she had collected at this time. Observation on 02/01/23 at 11:39 A.M. of the front door with the MD revealed there was no wander guard system on the front doors. The front doors had a secure code to enter to exit or if the doors are held for 15 seconds they would alarm and open. When Resident #36 had exited he had enter the code therefore the alarm did not sound when Resident #55 had exited. 3b. Observation on 02/01/23 at 12:38 P.M., revealed Resident #55 was attempting to exit out the side doors. Staff members were running down the hall to intervene. Interview on 02/01/23 at 10:05 A.M., with Corporate Nurse #55 revealed the facility had brought extra staff in this morning at 10:00 A.M. to provide one on one supervision to Resident #55 due to her exit seeking behaviors. The Corporate Nurse reported she did not know where the one-on-one person was during the incident witnessed by the surveyor at 12:38 P.M., however she would investigate. Interview on 02/01/23 at 4:22 P.M., with Corporate Nurse #55 revealed she provided education to STNA #25, (the staff member assigned to provide one on one supervision to Resident #55). The STNA reported she was helping staff deliver meal trays when Resident #55 was attempting to exit out the side doors earlier. Review of the Elopement and Wandering Resident policy (dated 10/01/22) revealed the facility would ensure that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk. Wandering is a random or receptive locomotion that may be goal-directed, or no-goal directed or aimless. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risk, implementing intervention to reduce hazards and risk, and monitoring for effectiveness and modifying interventions when necessary. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Also contained in the policy for monitoring and managing residents at risk for elopement or unsafe wandering revealed residents will be assessed for risk of elopement and unsafe wandering up admission and throughout their stay by the interdisciplinary. The interdisciplinary team will be evaluated the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behaviors, or to minimize risk associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. Charge nurse and unit manager will monitor the implementation of interventions, response to interventions, and document accordingly. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. Also contained in the procedure for post-elopement the nurse will perform a physical assessment, document, and report findings to the physician. Any new physician orders will be implemented and communicated to the family/authorized representative. A social service designee will re-assess the resident and make any referrals for counseling or psychological/psychiatric consult. The resident and family would be included in the plan of care. Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. When repeated elopements attempts occur, after the facility had exhausted possible care approaches, the resident may be refereed for alternate placement in an appropriate facility. Documentation in the medical record will include finding from nursing and social service assessments, physician/family notification, care plan discussion, and consults notes as applicable. This deficiency represents non-compliance investigated under Complaint Number OH00136553.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interview, and policy review the facility failed to ensure a resident was identified with significant weight loss. This affected one resident (#55) of three reviewed for weight loss. Findings included: Record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, dysphagia, psychosis, anxiety, hyperglycemia, gastro-esophageal reflux disease, depression, insomnia, and hypertension. Review of Resident #55's orders dated 01/2023 revealed the resident was ordered a regular diet, mechanical soft texture, regular-thin consistency liquids and house supplements 120 milliliters (ml) twice daily. Review of Resident #55's weight revealed the resident weighed 124 pounds on 01/04/23. Review of Resident #55's meal intakes dated 01/01/23 to 01/30/23 revealed the resident's meal intakes varied from 0-100%. Review of Resident #55's care plan for alteration in nutrition status related to variable by mouth intakes, revealed the resident required a mechanical altered diet, received oral nutrition supplements to maintain nutritional status, history of abnormal blood glucose to weigh at same time of day, using the same scale, and record per order. Monitor/record/report to the provider of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Interview on 01/30/23 at 12:39 P.M., with Resident #55's daughter revealed she had visited her mom on Sunday (01/29/23) and her mom appeared to have lost some weight. Her normal body weight was usually around 126. The Director of Nursing (DON) was notified on 01/30/23 at 1:13 P.M., of Resident #55's daughter concerns about the resident's weight loss and requested the resident to be weighed. On this date, the resident weighed 113 pounds. Interview on 01/31/23 at 12:09 P.M., with the DON revealed Resident #55's first weight was 113 pounds (on 01/30/23 after the surveyor requested the resident be weighed) and staff re-weighed the resident later and she was 115 pounds. The DON confirmed the resident was 124 pounds on 01/04/23, which indicates a 7. 3%-pound weight loss in one month. The DON reported she had a conference call with the Nurse Practitioner (NP), Resident #55's daughter, and herself last night. The NP was going to started Remeron at night for weight stimulant and staff was going to bring the resident out to the dining room for meals. (continued on next page)

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	365770	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled 'Weight Policy dated 03/01/22 revealed it was the facility policy to attain/maintain a resident's weight within the recommended range as appropriate in relation to their medical and physical status. This deficiency represents non-compliance investigated under Master Complaint Number OH00138950.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, review of narcotic control sheet, review of starter kit replacement forms, observation, interview, and policy review the facility failed to implement an effective and timely pain management program, including the timely administration of the opioid medication, Percocet administered at the correct ordered dose, for Resident #56. This affected one (#56) of three residents reviewed for pain. Actual Harm occurred to Resident #56 on 01/26/23 when Nurse Practitioner (NP) #65 increased the resident's Percocet to 7.5/325 milligrams (mg) every four hours as needed for acute pain. The order was written, however the Percocet 5 mg/325 mg tablets were not removed from the narcotic box and the resident received the lower dose (5 mg/325 mg) from 01/27/23 until 01/29/23 resulting in Resident #56 experiencing unnecessary and unmanaged pain leading to Resident #56 being unable to participate in stair training therapy on 01/27/23 and 01/30/23 due to right lower extremity pain and being unable to participate in therapy on 01/31/23 due to her pain being uncontrolled. Findings included: Record review revealed Resident #56 was originally admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including acute pain related to trauma, laceration of the spleen, fractured shaft right femur, open [NAME] fracture, fractured distal end right radius, multiple rib fractures, and low back pain. Review of Resident #56's pain plan of care related to bilateral rib fracture, right wrist fracture, right tibia fracture, surgical incisions with external fixation, and spleen laceration revised on 01/18/23 revealed make sure pain medication was ordered, administered, and evaluated. a. Observation revealed on 01/25/23 at 12:28 P.M., Resident #56's call light sounding as State tested Nurse's Aide (STNA) #25 was getting ready to take in Resident #56's lunch meal tray. The resident refused the lunch tray and requested a Tylenol and pain pill. The nurse was three doors down from Resident #56's room getting ready to administer medication to another resident. STNA #25 went immediately to Registered Nurse (RN) #59 and reported Resident #56 was requesting medication for pain. The nurse never returned to administer pain medication to Resident #56. The resident reported to the surveyor, her pain was currently rated a 7-8 on a scale of one to 10 and indicated her tolerable pain level was 3-4. On 01/25/23 at 1:05 P.M., the surveyor went to the nurse's station. RN #59 was not visible, however the medication cart was sitting across from the nurse's station. The surveyor explained to RN #3 and the Administrator that Resident #56 had requested something for pain around 12:28 P.M. from RN #59 and she still had not received her pain medication. RN #3 reported RN #59 had gone to lunch, however she would address it immediately. Interview on 01/25/23 at 1:31 P.M. with the Administrator revealed he had spoken to RN #59 and she did not have a reason why she did not administer pain medication to Resident #56 upon request and would go apologize to the resident. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	b. Interview on 01/25/23 at 12:30 P.M., with Resident #56 reported she had requested to see a physician since she was readmitted [DATE] due to her pain not being managed. The resident also voiced concerns staff didn't administer her pain medication timely and she has had to wait up to 40 minutes for staff to answer call light to request pain medications before. The resident reported was not full weight bearing yet and was not supposed to get up on her own, but if she didn't she would never get pain medication or assistance timely. The resident reported she usually had to track the nurse down because she could not wait any longer because the pain would be so bad. Interview on 01/25/23 at 2:29 P.M., with the Director or Nursing (DON) confirmed the resident had not been seen by a physician since she had returned from the hospital on 01/17/23. The DON indicated physician had been out of town and the Nurse Practitioner (NP) was covering his residents. The NP would be in the facility tomorrow and the DON indicated she would see if the NP would see the resident for pain and anxiety. Observation on 01/25/23 at 4:58 P.M. revealed Resident #56 was in the hall waiting for the nurse to come out of a room. The resident requested pain medication and RN #3 administered a Percocet 5/325 mg to the resident. RN #3 asked the resident her pain level. The resident reported no one had ever asked her her pain level before. Review of Resident #56's NP note, dated 01/26/23 revealed the resident reported her pain was not controlled in her wrist and leg. The resident was requesting to see pain management. New orders were received to increase Percocet to 7.5/325 mg every four hours and if not effective she would refer to orthopedics for adjustments. Review of Resident #56's physician orders, dated January 2023 revealed on 01/26/23 an order to administer Percocet 5/325 mg every four hours until 6:00 A.M. on 01/27/23. On 01/27/23 a new order was written for Percocet 7.5/325 mg every four hours as needed for pain. Review of Resident #56's narcotic control sheet dated 01/21/23 revealed 60 (5/325) mg Percocet tablets were delivered on 01/21/23. On 01/27/23 one tablet was administered at 8:30 A.M. and 8:00 P.M. On 01/28/23 one tablet was administered at midnight, 4:30 A.M., 8:21 P.M., and on 01/29/23 one tablet was administered at 4:23 A.M., 10:30 A.M., and 1:00 P.M The Percocet 5/325 mg order was discontinued on 01/27/23 at 6:00 A.M., however staff continued to administer this dose of the medication. Review of Resident #56's narcotic control sheet dated 01/29/23 revealed 60 Percocet 7.5/325 mg tablets were signed in 01/29/23. The label was dated 01/28/23 and the instructions were to administer one tablet every four hours as needed. On 01/29/23 one tablet was administered at 7:18 P.M. and 11:42 P.M. Review of the starter kit replacement forms dated 01/17/23 to 01/31/23 revealed no evidence Percocet 7. 5/325 mg tablets were removed for Resident #56. Review of Resident #56's Medication Administration Records (MAR) dated 01/2023 revealed the Percocet 5/325 mg was administered on 01/27/23 at 9:05 A.M., on 01/28/23 at 8:21 P.M., and 01/29/23 at 4:23 A.M., 10:17 A.M., 1:00 P.M., 7:18 P.M., and 11:42 P.M. when it was supposed to have been discontinued on 01/27/23 at 6:00 A.M. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #56's therapy notes dated 01/27/23 to 01/31/23 revealed the resident was not able to participate in stair training therapy on 01/27/23 and 01/30/23 due to right lower extremity pain. The resident was not able to participate in therapy at all on 01/31/23 due to pain. Interview on 01/30/23 at 10:25 A.M., with Resident #56 revealed she did not complete therapy today due to her pain not being controlled. The NP wrote new orders for medication Thursday (01/26/23) night, however staff reported the pharmacy had not delivered it yet. Observation and interview on 01/30/23 at 3:02 P.M., with Director of Nursing and Registered Nurse (RN) #59 revealed the Percocet 5/325 mg and the 7/325 mg reconcile with the narcotic sheets, which indicated the MARs were incorrect. The DON confirmed the resident received eight doses of the wrong strength of Percocet from 01/27/23 to 01/29/23. The resident should have received 7.5/325 mg, however received 5/325 mg. Interview on 01/31/23 at 5:30 P.M., with Resident #56's reported she was miserable and in pain over the weekend. The resident indicated the pain medication was still not helping today. She stated she did not go to therapy at all today due to the pain being so bad. The resident reported, the NP (NP #65) told her she didn't think she needed pain management, even though the hospital recommended it. Review of the facility's policy titled Pain Management dated 08/22/22 revealed the facility must ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Referral to pain management clinic for other interventions that need to administer under the close supervision of pain management specialist will be considered for residents with more advanced, complex, or poorly controlled pain. Review of the facility's policy titled Medication Administration dated 08/22/22 revealed mediation would be administered as ordered by a physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR to identify mediation to be administered and if the medication was a controlled substance, sign narcotic book. This deficiency represents non-compliance investigated under Complaint Number OH00138950.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, review of the facility's assessment, review of the staffing shortage letter, interviews, and observation revealed the facility failed to ensure adequate staffing levels to ensure residents care needs were met. This affected Residents #36, #44, #48, #55,#56, #59, #65 and had the potential to affect all 74 residents residing in the building. Findings include: 1. Review of anonymous complaints dated 11/16/22, 11/22/22, 01/04/23, and 02/06/23 revealed the facility was understaffed and not able to supervise residents to prevent falls and elopements. In addition showers and activities are not being done was well. The staffing issues were worse on evening and night shifts and weekends. 2. Review of Resident #44's medical record and fall documentation dated 11/14/23 to 01/31/23 revealed the resident had sustained 17 falls. Observation on 02/01/23 at 12:48 P.M. and 02/08/23 at 8:14 A.M., revealed Resident #44 attempting to stand without supervision and the surveyor had to intervene to prevent resident from falling until staff arrived. 3. Review of Resident #55's medical record and progress notes revealed the resident had eloped out of the building without staff supervision into an unsupervised area on 01/27/23 and 01/28/23. Observation on 02/01/23 at 12:28 P.M., revealed Resident #55 was attempting to exit a fire door without staff supervision. The resident was supposed to be on one on one supervision at the time of incident. 4. Review of Resident #44, #55, and #59's medical records revealed no evidence the residents were receiving activities per their plan of care. 5. Review of Resident #65's medical record revealed no evidence Resident #65 received showers per his preference. Interviews on 01/25/23 at 8:38 A.M., with the Ombudsman revealed she recently had concerns with staffing and call lights. Interview on 01/25/23 at 10:00 A.M., with anonymous staff #100 revealed the facility was short staffed. Sometimes showers are not completed. Interview on 01/25/23 at 12:30 P.M. and 01/30/23 at 10:25 A.M., with Resident #56 revealed the facility was short staffed. Call lights ring 40 minutes and then you still have to go look for staff. Resident #56 reported her pain was not managed due to staff not administering medication timely. Night and weekends the staffing was worse. There was not enough staff to supervise residents from eloping and falling. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/25/23 at 4:01 P.M., with Registered Nurse (RN) #5 verified the facility was short staffed. Interview on 01/26/23 at 10:22 A.M., with Resident #48 revealed the facility was short staffed. He volunteers to help around the facility. Resident #48 reported he doesn't use his call light, however he hears them going off for hours. He also has a friend in the facility that has not had a shower for three weeks. Interview on 01/26/23 at 2:35 P.M., with Resident #36 revealed the facility was short staffed. He had not had a shower for three weeks. He doesn't use his call light but hears them going off for long periods of time. Interview on 01/30/23 at 9:41 A.M., with Resident #65's family revealed there was not enough staff to answer call light, supervise wandering residents, and change bed linens. Call lights ring for 45 minutes and Resident #65 has called her at home for help and she would either call the facility or she would come to the facility to assist him. Interview on 01/30/23 at 1:13 P.M., with the Director of Nursing (DON) revealed she was aware there was a staffing issue, however she cannot get staff to apply. The facility was permitted to have three nurses on dayshift but they cannot find staff to work to fill those positions. This weekend they had one staff call off and one staff member that was a no call no show. Interviews on 01/31/23 from 1:26 P.M. to 6:00 P.M., with anonymous individuals #100, #101, #102, and #103 revealed there was not enough staff to supervise residents to prevent falls and elopements. Review of staffing storage letter dated 02/07/23 revealed the facility had two full Registered Nurse (RN) dayshift, one parttime RN night position, two full time dayshift Licensed Practical Nurse (LPN), three full time night shift LPNs, and one parttime night LPN, five full time dayshift State tested Nurses' Aides (STNA) and one full time night STNA positions that needed filled. Review of the facility's assessment dated [DATE] revealed under resident population there was 44 residents and the facility had 95 beds. The most common admitting diagnoses were diabetes, heart failure, wounds, dementia, fractures, sepsis, surgical aftercare, stokes, and Alzheimer's. The facility assessment revealed services/care offered based on the residents needs include assistance with activity of daily living, medication administration, pain management, infection prevention and control, nutrition services, skin care, fall and injury prevention, and pharmacy. The facility assessment revealed the facility cannot care for every applicant who wishes to receive our services. The facility cannot care for any residents with any of the following diagnoses and/or identified problems: person with major mental illness, and aggressive behaviors towards others. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility assessment revealed the facility's staffing is based on resident population and acuity. The facility staffing will be maintained minimum of 2.5 hours per patient day with variance dependent upon acuity. The organizational chart included the Administrator, DON, licensed staff, skin nurse, infection preventionist, scheduler, nurses' aides, and hospitality aides, human resources, billing officer, social service, activities director and staff, dietician, medical records, central supply manger, and environmental staff. There is no evidence of the number of staffing the facility would maintain. This deficiency represents non-compliance investigated under Master Complaint Number OH00138950 and Complaint Number OH00136553.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, observation, interview, and policy review the facility failed to ensure residents were free of significant medication errors for psychotropic medications. This affected two residents (#55 and #56) of three reviewed for medication review. Findings included: 1. Record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including psychosis, anxiety, depression, and anxiety. Review of Resident #55's nursing progress notes indicated the resident had exit seeking behaviors on 01/27/23, 01/28/23, and 01/29/23. Review of Resident #55's Medication Administration records (MAR) and orders dated 01/2023 revealed the resident was ordered Ativan 0.5 milligrams (mg) three times daily by mouth for anxiety, Buspar 5 mg three times daily for anxiety, Paxil 40 mg daily for depression, and Perphenazine 6 mg twice daily for psychosis. The Perphenazine morning dose was decreased to 2 mg from 01/17/23 to 01/24/23. The medication times had been changed on 01/24/23 and then changed back on 01/27/23. Further review of the MAR indicated on 01/25/23 the early dose of Ativan, Buspar, Paxil, and Perphenazine were not signed off as administered and on 01/27/23 the 2-5 P.M. dose of Ativan and Buspar were not signed off as administered. Review of the Ativan control sheet dated 01/17/23, with the Director of Nursing on 01/30/23 at 3:02 P.M., revealed the Ativan label indicated one tablet by mouth two times daily and one tablet by mouth two times a day as needed for anxiety and agitation. There was only one Ativan card, and the label did not match the order. Further review of the Ativan control sheet revealed on 01/22/23 the resident received four Ativan (order was for only TID) and the administration times were out of sequence. According to the control sheet, the first dose was given at 6:00 A.M., second dose at 1:00 A.M. which should have been signed out before the 6:00 A.M. dose, third dose at 11:30 A.M., and fourth dose at 8:00 P.M. The MAR only indicated three doses were administered. On 01/23/23, the control sheet only indicated two doses of Ativan was signed out at 6:00 A.M. and 8:00 P.M., however the MAR indicated three doses of Ativan were administered. On 01/26/23 there was four doses of Ativan signed out as administered, however there was three doses signed off on the MAR. At this time, the DON confirmed staff administered Resident #55 Ativan without orders on 01/22/23 and 01/26/23 when they administered a fourth dose of Ativan and on 01/23/23 staff only administered two doses of Ativan's and the order was for three times. The DON confirmed the MAR did not match the narcotic control sheets on 01/22/23, 01/23/23, and 01/26/23. Staff were administering Ativan without orders on 01/22/23 and 01/26/23 and the MAR did not match the narcotic sheets on 01/22/23, 01/23/23, and 01/26/23. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/30/23 at 12:39 P.M., with Resident #55's daughter revealed she was unaware of any medication changes, including dose reductions and discontinuing the as needed Ativan, and changing medication times. Resident #55's daughter indicated when she had visited the resident on 01/29/23 the resident was tearful and had increased exit seeking behaviors. Interview on 01/30/23 at 3:02 P.M., with the Registered Nurse (RN) #59 confirmed on 01/25/23 the early dose of Ativan, Buspar, Paxil, and Perphenazine were not signed off as administered and on 01/27/23 the 2-5 P.M. dose of Ativan and Buspar were not signed off as administered as well. The RN reported the MDS nurse had changed times of resident medication on 01/24/23 to even out the medication administration pass between day and night shift not considering the medications. The RN gave an example of the Resident's Ativan's lunch does could be administer between 11-12 P.M. and then she had it scheduled again at 2-5 P. M. So, the resident could possible get Ativan at 12 and then again at 2 P.M., which would be too close together to administered. On 01/28/23 a nurse reviewed the medication times again and moved some medications back to the original times. Resident #55's Ativan 2-5 P.M. dose was moved back to at night 6 P. M. The RN reported Resident #55 needed her medication administered further apart to prevent behaviors occurring in the evening. Interview on 01/31/23 at 12:09 P.M., with the DON revealed she has spoken to the residents daughter and the Nurse Practitioner (NP) via phone last night in regards to the elopements, medication changes/errors, and weight loss. The NP ordered Ativan as needed for 14 days and the resident was placed on one on one supervision until Resident #55's behaviors improved. 2. Record review revealed Resident #56 was originally admitted to the facility on [DATE] and readmitted on [DATE] with depression and anxiety. Interview on 01/25/23 at 12:30 P.M., with Resident #56 revealed she had returned to the facility on [DATE] and had requested to see a physician for anxiety and pain, however she still had not seen a physician. Interview on 01/25/23 at 2:29 P.M., with the DON confirmed Resident #56 had not seen a medical provider since she had returned from the hospital on 01/17/23 and she will see if the Nurse Practitioner (NP) will see her tomorrow. Interview on 01/30/23 at 10:25 A.M. with Resident #56 revealed the NP had visited her Thursday (01/26/23) and had ordered Ativan, however when the resident requested the Ativan, staff told her that pharmacy had not delivered the Ativan yet and it was not available. Resident #56 reported her anxiety was so bad she was having trouble sleeping. Review of Resident #56's NP note dated 01/26/23 revealed the NP ordered Ativan as needed for 14 days for anxiety. Review of Resident #56's control sheet dated 01/29/23 revealed the facility received Ativan 0.5 milligrams (mg) daily at bedtime as needed. Further review of the control sheet revealed Resident #56 received the first dose of Ativan on 01/29/23 at 11:42 P.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/30/23 at 3:02 P.M., with the DON confirmed the NP ordered Ativan on 01/26/23, however the pharmacy did not fill the order until 01/28/23 and the facility did not receive the medication until 01/29/23. Review of the facility's policy titled Medication Administration dated 08/22/22 revealed medication would be administered as ordered by a physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR to identify medication to be administered and if the medication was a controlled substance, sign narcotic book. This deficiency represents non-compliance investigated under Complaint Number OH00136553.

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	365770	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Cambridge	1471 Wills Creek Valley Drive Cambridge, OH 43725

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure stool samples were collected per physician orders. This affected two residents (#65 and #79) of three residents reviewed for laboratory services. Findings included: 1. Review of Resident #65's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including acute osteomyelitis in left ankle and foot, gastric reflux disease, heart failure dysphagia, anxiety, type two diabetes, and benign prostatic hyperplasia. Review of Resident #65's orders revealed stool cultures were ordered on 12/23/22 and 12/30/22. Record review revealed no evidence the stool culture ordered on 12/23/22 was obtained by the facility. Record review revealed no evidence the stool culture ordered on 12/30/22 was obtained by the facility. Interview on 01/30/23 at 9:41 A.M., with Resident #65's family revealed the resident was ordered stool testing for C-Diff prior to being sent to the hospital and it was never completed. The family was told the first specimen was lost and the second was still in the refrigerator and was never sent. Interview on 02/02/23 at 9:30 A.M. with the Director of Nurse (DON) and Regional Director of Clinical Operations #55 verified Resident #65's stool cultures were not obtained per order on 12/23/22 or 12/30/22 and Resident #65 was hospitalized from 01/02/23 to 01/11/23 for a diagnosis and treatment of C-Diff. 2. Closed record review revealed Resident #79 was admitted to the facility on [DATE] with diagnoses including dependence of renal dialysis, atrial fibrillation, and diabetes. Review of Resident #79's orders dated 12/26/22 revealed to obtain stool sample x 3 to check for occult blood per dialysis. Record review revealed no evidence the stool samples ordered on 12/26/22 were obtained by the facility. Interview on 02/08/23 at 3:18 P.M., with the DON confirmed Resident #79's stools were not collected per orders. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Diagnostic Testing Services dated 10/01/22 revealed the facility would provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with State and Federal guidelines. The facility would maintain a schedule of diagnostic tests in accordance with the physician orders. No diagnostic test will be performed without specific physician, physician assistant, nurse practitioner or clinical nurse specialist orders in accordance with State law to include scope of practice law. Qualified nursing personnel will receive and review the diagnostic teste reports and communicate the results to the ordering physician within 24 hours of receipt unless that report results fall outside the clinical reference ranges and require immediate attention at which time the physician would be notified upon receipt. Documentation of the test results, date/time of Physician notification would be maintained in the resident's clinical records. This deficiency represents non-compliance investigated under Complaint Number OH00136553.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32801 Based on interviews and observation the facility failed to ensure meals were appetizing and palatable. This had the potential to affect all 74 residents residing in the building. Findings included: Observation on 01/25/23 at 12:38 P.M., of lunch meal service revealed the beef and noodles were dry and shaped like a scoop (ball) and the vegetables had no color. During the observation, an unidentified male resident in the dining room had pointed at the beef and noodles and asked staff what it was supposed to be. Interview on 01/25/23 at 12:38 P.M., with anonymous staff member #100 revealed residents complain the food was not good or served cold. Interview on 01/25/23 at 12:30 P.M., with Resident #56 revealed the food was awful. Resident #56 reported she was not aware there was an alternative menu. At the time of the interview, observation revealed the resident's breakfast tray was still in her room untouched. Per Resident #56, staff tell her they don't have food for people her age. Interview on 01/26/23 at 2:10 P.M., with Resident #31 revealed the food was too hard to chew and she was tired of eating grilled cheese. Interview on 01/26/23 at 2:35 P.M., with Resident #36 revealed the food tastes like crap. Resident #36 reported he had lost 51 pounds since 10/01/22. The dietician ordered double portions. The resident reported now he was getting double portions of crap. The kitchen doesn't prepare nutritional meals. A cup of soup and peanut butter and jelly sandwich was not a balanced meal for dinner. He goes to bed hungry and wakes up hungry, but he must eat the food because that's all he had to eat. The facility cut the dietary budget when the census was low and now it was in the 70 and they did not increase the budget. Interview on 01/30/23 at 9:41 A.M., with Resident #65's wife and daughter revealed the resident had lost weight, however he was diabetic and the kitchen sends him mashed potatoes every day and he should not have so many carbohydrates. Interview on 01/30/23 at 10:25 A.M., with Resident #56 revealed she had requested an alternative meal on Friday and never got it or explanation on why she did not receive it. Interview on 01/30/23 at 1:13 P.M., with the Dietary Manger revealed the floor staff don't always turn in the alternative meal tickets for residents and the food carts out on the floor too long causing the food to be cold. Interview on 01/31/23 from 1:26 P.M. to 3:17 P.M., with anonymous staff #102 and #103 revealed residents complain every day about the food. Some residents feel the food was dry and they cannot chew most of the food because they don't have teeth or don't wear their dentures. The kitchen was frequently out of alternative foods. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This deficiency represents non-compliance investigated under Master Complaint Number OH00138950.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure a complete and accurate medical record in the area of resident change of condition related to death. This affected one resident (#80) of four reviewed for death. Findings included: Record review revealed Resident #80 was admitted to the facility on [DATE] and expired on [DATE]. Review of Resident #80's orders dated ,d+[DATE] revealed the resident was a full code. Review of Resident #80's nursing notes dated [DATE] to [DATE] revealed the resident was admitted on [DATE] at 3:00 P.M. and had complaints of shortness of breath at times and rhonchi noted in his lungs. The resident was a smoker. The resident was alert and oriented and denied pain. The next nursing note dated [DATE] at 3:00 A.M., indicating the resident's lungs were clear and the resident was tired and had little energy. The next nursing note dated [DATE] at 4:47 P.M., indicated the family arrived to make final visit before the body was transferred to a university hospital. The last nursing note dated [DATE] at 10:45 P.M., revealed the resident's body left the facility to be donated to science. There was no documented evidence of the resident's change of condition, if cardiopulmonary resuscitation was performed, and when the resident was pronounced dead, or physician notification. Interview on [DATE] at 4:03 P.M. with Registered Nurse (RN)#18 revealed after she had received report that morning, she had started her medication pass when an aide reported she did not think Resident #80 was breathing. She ran into his room and assessed the resident. The resident did not have a pulse or respiration. RN #5, the other nurse in the facility, arrived and reported the resident was a full code and CPR was initiated. The aide called 911 and CPR was continued until the squad had arrived about 20 minutes later. #18 reported thought she had charted the incident. Interview on [DATE] at 4:05 P.M., with RN #5 confirmed she had assisted RN #18 with CPR when Resident #80 was found unresponsive. RN #5 was not the resident's nurse that day, but therapy had come to her unit and reported a resident was coding on the other unit. Resident #80 was a full code and when she entered Resident #80's room the staff were standing over the resident. RN #5 started CPR and another staff member called the physician and was told to continue CPR until the squad arrived. RN #5 confirmed she did not document the incident and she returned to her unit to continue care with her residents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:04 A.M., via email with the Director of Nursing (DON) confirmed Resident #80's medical was not complete and accurate regarding Resident #80's change in condition and the initiation of CPR. Review of the facility's policy titled Notification of Change dated [DATE] revealed the physician would be notified of the resident death immediately. Review of the facility's policy titled Pronouncement of Death dated ,d+[DATE] revealed the documentation should include: time the resident was noted to be without vital signs, action completed, who pronounced death and time, times of notification and attempts of notification, and other relevant information. This deficiency represents non-compliance investigated under Complaint Number OH00136553.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of statements, review of hospice contract, interviews, and policy review the facility failed to ensure hospice services were provided to meet professional standards regarding a resident's release to a funeral home. This affected one resident (#75) of three reviewed for hospice services. Findings included: Closed record review revealed Resident #75 was admitted to the facility on [DATE] and expired on [DATE] under hospice care. The resident's diagnoses included respiratory failure, heart failure, and diabetes. Review of Resident #75's nursing progress notes dated [DATE] revealed at 11:00 A.M., the hospice nurse visited the resident and family was at the bedside. The progress note identified the resident had cyanosis noted to hands, nailbeds, feet, toes, and lips. The progress note on [DATE] at 4:30 P.M., revealed Resident #75 remained resting in bed with head of bed (HOB) elevated. Family remained at bedside, respirations were 6, mouth breathing noted. Both feet were cyanotic, hands, nailbeds dark purple in color. Resident #75 was medicated PRN per physician order and family's request. Resident #75's skin was pale, cool to touch, and the resident was non-responsive to any stimuli. On [DATE] at 11:38 P.M., the nurse checked Resident #75 for apical/carotid pulse and respirations. The resident's apical pulse was slow and sporadic and respiration shallow with periods of apnea noted. Family made aware. On [DATE] at 11:55 P.M., Resident #75 was noted to have not taken breaths for a few minutes. A second nurse confirmed Resident #75 was absent of vital signs at this time. Resident #75's son was notified. On [DATE] at midnight, the hospice provider was notified. Review of Resident #75's nursing progress note dated [DATE] revealed at 2:30 A.M., the resident's body was released to the funeral home. Further review of Resident #75's medical record revealed no evidence the resident's preference of funeral home was documented in the medical record. There was no evidence staff verified the funeral home preference with family. Interview on [DATE] at 2:29 P.M., with the Director of Nursing (DON) verified the facility did not have Resident #75's funeral home preference documented in the medical record; however, the hospice provider notified the wrong funeral home. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 4:27 P.M., with Hospice Nurse #111 verified Resident #75 was admitted to hospice on [DATE] and was a DNR. A hospice nurse had visited that day, [DATE], (not sure of time). The resident was having periods of apnea. The visiting hospice nurse answered end of life questions for the family, which was present during the visit. Staff were told to report any changes, uncontrolled symptom, death, or call if the family would like hospice to be there. The family did not voice any concern about her care at that time. Hospice Nurse #111 reported it was partially her error regarding the nursing funeral. She had done the resident's admission and had two residents with the same first name and last initial that day and entered the same funeral home for both residents. She had the correct funeral home on the intake paper, however transcribed incorrectly when entering the information in the computer. The nurse that took the call from the nursing home did not verify the funeral home. Resident #75's son had called the next day and left her a message. When she called him back, he told her that his mom was sent to the wrong funeral home. Per Hospice Nurse #111, sometimes the facilities call the funeral home after death and sometimes Hospice does. This case (with Resident #75) the on-call hospice nurse called the funeral home and did not verify with the family as well. Review of the facility's contract with Resident #75's hospice service (dated [DATE]) revealed hospice and the facility would communicate with each other regarding the hospice patient's condition through telephone, in-person verbal communication, and if appropriate written communication in the medical record. The facility shall immediately notify hospice if there was a significant change in the patients physical, mental, social, or emotional status. Review of the facility's policy titled Pronouncement of Death (dated ,d+[DATE]) revealed a nurse would assess the clinical indications of death such as: absence of respiration by use of stethoscope, absence of pulse by listening for apical heartbeat, absence of blood pressure, and absence of pupil contraction/dilation by use of a flashlight. A resident may be declared dead by a Licensed Physician or other licensed healthcare provider within the scope of their practice. A nurse was not authorized to pronounce death unless authorized by a physician, or a Hospice Registered Nurse in accordance with state law. In a case of the death of a resident the physician and family would be notified and the pre-determined, funeral home, or one chosen by the family would be notified. A release form would be signed by the funeral home representative upon pickup of the body. Documentation should include the time the resident was noted to be without vital sings, actions completed, times of notification or attempts of notification, when and by whom the body was picked up, disposition of personal property, and other relevant information. This deficiency represents non-compliance investigated under Complaint Number OH00136553.